PRINCETON Radiation Oncology

9 Centre Drive, Suite 115
Monroe, NJ 08831
phone 609-655-5755 • fax 609-655-5725
www.PrincetonRadiationOncology.com

Patient Information

Today's Date: _____

Full Name (Last, First, MI): _____

Date of Birth: _____ □ Male □ Female **SSN:** _____

Address (Street, City, Zip code): _____

Email address: _____ May we email you? □ Yes □ No

Phone (check preferred contact): □ Home _____ □ Cell _____
May we leave a message on your answering machine / voicemail? □ Yes □ No

Employed: □ No □ Yes: Occupation _____ Work phone _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Emergency Contact Name: _____ Relationship _____ Phone_____

Power of Attorney (if applicable): _____ Relationship _____

Race:
□ African American □ Caucasian □ Unknown □ Other _____
□ Asian □ Hispanic □ Decline to provide

Ethnicity:
□ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language:
□ English □ Spanish □ Other _____

List the physicians you would like to receive communication:

Name	**Specialty**	**Phone**

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Patient Name: _____ **Date:** _____

Do you have an Advanced Directive (Living Will)? □ Yes □ No

Do you have a previous diagnosis of cancer? □ No □ Yes, type/year:

_____

Medical Problems	**Surgery: Type and date**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please check any Medical Devices / Implants:

□ Pacemaker □ Infusion Port □ Dialysis access / catheter
□ Defibrillator □ Insulin pump □ VP Shunt

Date of last Flu vaccine: _____ **Date of Pneumococcal vaccine:** _____

Do you currently, or, have you ever smoked or used tobacco? □ No □ Yes
If Yes, type _____ How much per day _____ # of years _____ Year quit _____

Do you drink alcohol? □ No □ Yes If Yes, what kind _____ How many drinks per day _____

Were you ever exposed to any occupational hazards (such as asbestos, chemicals, coal dust)?
_____

FEMALE PATIENTS ONLY:

Last mammogram: _____ **Last Bone Density Scan:** _____

Last pap smear: _____ **Age of menses:** _____ **Age at menopause:** _____

Age at 1st pregnancy: _____ **Number of pregnancies:** _____ **Number of Deliveries:** _____

History of hormone replacement therapy □ No □ Yes If yes, how many years? _____

History of oral contraceptive use? □ No □ Yes If yes, how many years? _____

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Patient Name: _____ **Date:** _____

Medications: Please list any medications you are taking at this time (including hormones and vitamins)

☐ Check if copy of medication list is attached

Medication	**Dose**	**How often**	**How taken (oral/injection/topical)**

Pharmacy Name: _____ Pharmacy Phone: _____

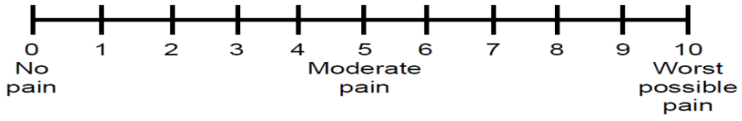
Pharmacy Address: _____

Do you have a latex allergy? ☐ No ☐ Yes **Do you have an allergy to IV contrast?** ☐ No ☐ Yes

Do you have any medication allergies? ☐ No ☐ Yes - please list below:

Medication Allergy	**Reaction**

Pain Rating - If you have pain, where is it located? _____



Nursing Notes (For Office Use Only):

_____

_____

_____

RN initials _____

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Patient Name: _____ **Date:** _____

Review of Systems: *Please check any symptoms you are currently experiencing:*

Constitutional
□ Fatigue
□ Fever
□ Chills
□ Night sweats
□ Difficulty Sleeping
□ Weight loss >10 lbs.
□ Weight gain >10 lbs.

Head and Neck
□ Hearing changes
□ Eye pain
□ Ear pain
□ Oral sores
□ Dry Mouth
□ Change in voice
□ Sore throat
□ Difficulty swallowing
□ Jaw pain

Skin
□ Itching
□ Rashes
□ New or changed mole
□ Unhealed sores
□ Nail changes
□ Change in skin color

Cardiovascular
□ Chest pain
□ Palpitations
□ Dizziness or fainting
□ Leg swelling

Respiratory
□ Shortness of breath
□ Wheezing
□ Cough
□ Coughing up blood

Gastrointestinal
□ Loss of appetite
□ Indigestion/heartburn
□ Bloating
□ Abdominal pain
□ Nausea/vomiting
□ Diarrhea
□ Constipation
□ Rectal bleeding
□ Incontinence
□ Date of last colonoscopy: _____

Neurological
□ Headaches
□ Visual changes
□ Dizziness
□ Memory loss
□ Confusion
□ Numbness/tingling
□ Muscle weakness
□ Unsteady gait

Lymphatics
□ Easy bruising
□ Swollen glands
□ Swelling of arm/leg

Endocrine
□ Increased thirst
□ Increased urination
□ Hair changes
□ Cold intolerance

Psychiatric
□ Anxiety
□ Depression

Musculoskeletal
□ Joint swelling
□ Muscle or joint pains
□ Back pain
□ Bone pain

Genitourinary
□ Frequent urination
□ Urinary urgency
□ Urinary burning
□ Blood in urine
□ Incontinence

GU - Male
□ Impotence
□ Testicular pain
□ Penile pain

Breast
□ Breast Mass
□ Breast Pain
□ Nipple Discharge

Have any members of your family (blood relatives) had cancer? □ No □ Yes, please list:

Relationship	Cancer	If deceased, age	Comments

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Patient Name: _____

Primary Insurance Carrier

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Where did you learn about Princeton Radiation Oncology?

☐ Physician Referral ☐ Family / Friends ☐ Insurer

☐ Advertisement ☐ Internet Search ☐ RCCA Website

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible.

I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

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REQUEST FOR RELEASE OF MEDICAL RECORDS

I, _____, request a copy of my complete medical record from the office of:

_____

Name and Address of Practitioner / Facility

To be sent to: Princeton Radiation Oncology
9 Centre Drive, Suite 115
Monroe, NJ 08831
Phone: 609-655-5755
FAX: 609-655-5725

I give permission to fax my medical records to the above listed person, company or medical facility. I understand my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Princeton Radiation Oncology to receive copies of any medical, psychiatric, Aids Related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire 1 year after the date below or sooner at my election.

_____ _____
Print Patient Name Date

_____ _____
Signature Patient, Parent, or Legal Guardian/Representative Date

_____ _____
Witness Date

Princeton Radiation Oncology / Regional Cancer Care Associates LLC ("RCCA") is committed to protecting the privacy of individual health information in compliance with the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act (both Acts together, "HIPAA") and the regulations promulgated there under. These policies and procedures apply to protected health information ("PHI") created, received, maintained or transmitted by RCCA after April 13, 2013.