



# Astera Cancer Care

PRINCETON RADIATION ONCOLOGY

**New Patient Packet**

## New Patient Medical History

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Male  Female                      SSN: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Primary Phone: \_\_\_\_\_  Home  Cell

Secondary Phone: \_\_\_\_\_  Home  Cell

May we leave a message on your answering machine / voicemail?                       Yes     No

Email Address: \_\_\_\_\_ May we email you?                       Yes     No

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Power of Attorney (if applicable): \_\_\_\_\_ Relation to you: \_\_\_\_\_

Living Will:     Yes\*    No        *\*Please provide a copy for your records*

Preferred Language: \_\_\_\_\_

Race:  White    Hispanic/Latino    Black/African American    Native American    Asian/Pacific Islander    Other

Ethnicity:  Hispanic or Latino    Not Hispanic or Latino

Are you:  Employed    Unemployed    Retired    Disabled

(Former) Occupation: \_\_\_\_\_

Marital Status:  Married    Single    Widowed    Divorced    Domestic Partner

Lives alone    Lives with family

Children         Yes    No

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician (if different): \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

Surgical History: Please list all surgeries you have had with approximate date:

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Implanted Medical Devices (Check all that apply):

Pacemaker  Defibrillator  Infusion Port  Insulin Pump  Dialysis Access Port  VP Shunt

**Social History**

Tobacco User:

- Never Smoked  
 Quit Smoking When did you quit? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_ Yr(s)  
 Currently smoke: What age did you start? \_\_\_\_\_ How many packs? \_\_\_\_\_ /day

Alcohol User: Present or Past

- Non-Drinker  
 Drinker  Current  Past How many drinks per day? \_\_\_\_\_

**Health Maintenance:** \_\_\_\_\_

Sigmoidoscopy / Colonoscopy:  Yes  No Date: \_\_\_\_\_ Influenza (Flu) Shot:  Yes  No Date: \_\_\_\_\_

Mammogram:  Yes  No Date: \_\_\_\_\_ Pneumococcal Shot:  Yes  No Date: \_\_\_\_\_

Bone Density:  Yes  No Date: \_\_\_\_\_ COVID-19 Shot:  Yes  No Date: \_\_\_\_\_

Pap Smear:  Yes  No Date: \_\_\_\_\_

Females:

Age of 1st Pregnancy: \_\_\_\_\_ # of Pregnancies: \_\_\_\_\_ # of Deliveries: \_\_\_\_\_ Did you breastfeed?  Yes  No First day of last menstrual period: \_\_\_\_\_ Age of first period: \_\_\_\_\_ Age of menopause: \_\_\_\_\_

History of Hormone Replacement Therapy?  Yes  No If Yes, How many years?: \_\_\_\_\_

History of Oral Contraceptive use? Yes No

**Other Medical History not listed above:**

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**Patient Name:** \_\_\_\_\_

**Family History**

	Age	Alive/Deceased	Health Status	Medical History
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Children	_____	_____	_____	_____

**Family History of Cancer:** Indicate any family members with cancer, blood disease or other disease

	Age	Alive/Deceased	Type of Cancer
Mother	_____	_____	_____
Father	_____	_____	_____
Daughter	_____	_____	_____
Son	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____

		Age diagnosed	Type of Cancer
Aunt	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	_____	_____
Uncle	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	_____	_____
Grandmother	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	_____	_____
Grandfather	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	_____	_____
Cousin / 1st – 2nd	<input type="checkbox"/> Maternal <input type="checkbox"/> Paternal	_____	_____

Have you had genetic testing done?  Yes     No    Have any of your family members had genetic testing?  Yes     No

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

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

**Pharmacy Name:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_

**Pharmacy Address:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

 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? \_\_\_\_\_


 Reason for this Visit: \_\_\_\_\_  
 \_\_\_\_\_

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

- |  |  |  |  |
|--|--|--|--|
| <b>Constitutional</b><br><input type="checkbox"/> Fatigue<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Chills<br><input type="checkbox"/> Night sweats<br><input type="checkbox"/> Difficulty Sleeping<br><input type="checkbox"/> Weight loss >10 lbs.<br><input type="checkbox"/> Weight gain >10 lbs.<br><br><b>Head and Neck</b><br><input type="checkbox"/> Hearing changes<br><input type="checkbox"/> Eye pain<br><input type="checkbox"/> Ear pain<br><input type="checkbox"/> Oral sores<br><input type="checkbox"/> Dry Mouth<br><input type="checkbox"/> Change in voice<br><input type="checkbox"/> Sore throat<br><input type="checkbox"/> Difficulty swallowing<br><input type="checkbox"/> Jaw pain<br><br><b>Skin</b><br><input type="checkbox"/> Itching<br><input type="checkbox"/> Rashes<br><input type="checkbox"/> New or changed mole<br><input type="checkbox"/> Unhealed sores<br><input type="checkbox"/> Nail changes<br><input type="checkbox"/> Change in skin color | <b>Cardiovascular</b><br><input type="checkbox"/> Chest pain<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Dizziness or fainting<br><input type="checkbox"/> Leg swelling<br><br><b>Respiratory</b><br><input type="checkbox"/> Shortness of breath<br><input type="checkbox"/> Wheezing<br><input type="checkbox"/> Cough<br><input type="checkbox"/> Coughing up blood<br><br><b>Gastrointestinal</b><br><input type="checkbox"/> Loss of appetite<br><input type="checkbox"/> Indigestion/heartburn<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Abdominal pain<br><input type="checkbox"/> Nausea/vomiting<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Incontinence | <b>Neurological</b><br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Visual changes<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Memory loss<br><input type="checkbox"/> Confusion<br><input type="checkbox"/> Numbness/tingling<br><input type="checkbox"/> Muscle weakness<br><input type="checkbox"/> Unsteady gait<br><br><b>Lymphatics</b><br><input type="checkbox"/> Easy bruising<br><input type="checkbox"/> Swollen glands<br><input type="checkbox"/> Swelling of arm/leg<br><br><b>Endocrine</b><br><input type="checkbox"/> Increased thirst<br><input type="checkbox"/> Increased urination<br><input type="checkbox"/> Hair changes<br><input type="checkbox"/> Cold intolerance<br><br><b>Psychiatric</b><br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Depression | <b>Musculoskeletal</b><br><input type="checkbox"/> Joint swelling<br><input type="checkbox"/> Muscle or joint pains<br><input type="checkbox"/> Back pain<br><input type="checkbox"/> Bone pain<br><br><b>Genitourinary</b><br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Urinary urgency<br><input type="checkbox"/> Urinary burning<br><input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Incontinence<br><br><b>GU - Male</b><br><input type="checkbox"/> Impotence<br><input type="checkbox"/> Testicular pain<br><input type="checkbox"/> Penile pain<br><br><b>Breast</b><br><input type="checkbox"/> Breast Mass<br><input type="checkbox"/> Breast Pain<br><input type="checkbox"/> Nipple Discharge |
|--|--|--|--|

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Primary Insurance Carrier:** \_\_\_\_\_ Policy ID#: \_\_\_\_\_

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 the plan have prescription coverage?  Yes  No

**Secondary Insurance Carrier:** \_\_\_\_\_ Policy ID#: \_\_\_\_\_

Name of secondary 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 the plan have prescription coverage?  Yes  No

How did you learn about Astera?

- Physician Referral       Family / Friends       Insurer  
 Advertisement       Internet Search       Astera 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: \_\_\_\_\_

Print Name: \_\_\_\_\_

## Request For Release Of Records

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

Name and Address of Practitioner: \_\_\_\_\_

To be sent to Astera Cancer Care: \_\_\_\_\_

Address, City State Zip Code: \_\_\_\_\_

Fax/Telephone Number: \_\_\_\_\_

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

Provide office fax number: \_\_\_\_\_

It is my understanding that by signing this authorization for release of my records, I am giving permission for Astera Cancer Care to receive copies of any medical, psychiatric, AIDS, 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

Astera Cancer Care 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 Astera Cancer Care after April 1, 2021.

## USE OR DISCLOSURE AUTHORIZATION FORM

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**Name of Individual Authorizing Use or Disclosure**

**Telephone Number**

*I hereby authorize the use and/or disclosure of my Protected Health Information by Astera Cancer Care as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health care provider or health plan, the released information may be re-disclosed and may no longer be protected by the federal privacy laws and regulations.*

1. The following health information will be disclosed (please check):

- Cardiac studies
- Complete record
- Consultations (including psychiatric evaluations)
- Discharge Summary
- Emergency Department Record
- History & Physical Examination
- Interdisciplinary Records (Progress Notes)
- Laboratory Reports (including drug screens)
- Medication Records
- Nursing Notes
- Operative and/or Procedure reports
- Physician Orders
- Radiology or Imaging Reports
- All of the above
- Other: (fill below)

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2. Person or organization authorized to receive the health information (for example: names of family, caregivers and friends, health insurance, health plan, other providers administering care coordination services):

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3. Description of each purpose for which the health information will be used/disclosed (Note: if the individual elects not to provide a reason, insert "At the request of the individual"):



## USE OR DISCLOSURE AUTHORIZATION FORM (continued)

4. I understand that the person or organization that I am authorizing to use or disclose the information may receive compensation in exchange for the health information described above.
5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits. \*
6. I understand that I may revoke this authorization at any time by providing written notice to Astera Cancer Care, J-2 Brier Hill Court, East Brunswick, NJ 08816.
7. I understand that my revocation of this authorization will not affect any actions already taken in reliance on this authorization or certain actions listed in the Astera Cancer Care Notice of Privacy Practices.
8. I understand that I may inspect or copy any information to be used or disclosed under this authorization.
9. Unless otherwise revoked in writing, this authorization will expire \_\_\_\_\_ days from the date signed below. If this date is left blank, the authorization will automatically expire one (1) year from the date I sign below.
10. Submitted to Astera Cancer Care.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative  
(Print)

\_\_\_\_\_  
Description of Personal Representative's Authority

\*A health plan may condition enrollment or eligibility for benefits on an individual providing an authorization prior to enrollment if the authorization sought is for the plan's eligibility or enrollment determinations relating to the individual or for its underwriting risk or risk rating determinations and the authorization is not for a use or disclosure of psychotherapy notes (45 C.F.R. § 164.508(b)(4)(ii)(A&B)).

## BILLING POLICY PATIENT AGREEMENT

I acknowledge that I am responsible for payment of the fee for medical services rendered by Astera Cancer Care, regardless of any reimbursement to which I may be entitled by reason of insurance or legal claims. I am aware that it is solely my responsibility to know, in advance of the service, the benefits and guidelines of my individual insurance coverage; to obtain all necessary insurance referral forms and/or pre-certification; and to confirm plan in which Astera Cancer Care, is a participating provider, the payment guidelines of my plan will prevail. I authorize Astera Cancer Care to prepare and submit the appropriate claim forms to my primary and secondary (if any) insurance carrier (s). I hereby assign all insurance benefits relating to these medical services to Astera Cancer Care and authorize the release of all information necessary to effect payment of those benefits. Even though payment may be sent directly to Astera Cancer Care, I understand that I am still responsible for any balance remaining and will pay any amount not covered by my insurance. I understand that if I fail to keep any financial agreement, I make with Astera Cancer Care and my account must be sent to a collection agency, I will be responsible for all collections cost and legal fees.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient or Patient's Representative Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Today's Date

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By my signature below, I am acknowledging I have received a copy of the Astera Notice of Privacy Practices concerning the uses and disclosures of my Protected Healthcare Information in accordance with the HIPAA Privacy and Security Rules.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Patient or Patient's Representative Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Today's Date

Rev: 1-25-2022

