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Cancer Center
of Middle Georgia

Arvind Aggarwal, MD
Harsha Vyas, MD

Patient Information

Last Name: _____ Middle Initial: ___ First Name: _____

Date of Birth: _____ SSN: _____ Gender: M / F

Race: Caucasian ___ Black ___ Asian ___ Hispanic ___ Native American ____ Other ____
Preferred Language: English ___ Spanish ___ Other _____

Marital Status: Single __ Married __ Divorced __ Widowed __ Other __

Spouse Name: _____ Phone: _____

Mailing Address: _____

Daytime Phone: _____Evening Phone _____

Emergency Contact #1: _____ Phone: _____

Primary Care Physician: _____Phone: _____

Pharmacy: _____ Phone: _____

I give consent to retrieve RX History: YES _____ NO _____

Referring Physician: _____ Phone: _____

Insurance Information

(Insurance cards must be provided every appointment)

Primary Insurance Company: _____ Member ID: _____

Policy Holder Name:(If other than patient) _____ DOB: _____

Secondary Insurance Company: _____ Member ID: _____

Policy Holder Name: (If other than patient) _____ DOB: _____

I understand I will be charged a $30 Fee for No-show appointments and cancellations made less than 24 hours prior to my appointment.

Patient Signature: _____ Date: _____

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Medical History Questionnaire

Patient Name: _____ DOB: _____

Have you ever had any of the following conditions? Please check yes or no and date problem started.

Condition or Disease	Y	N	Date Diagnosed	Condition or Disease	Y	N	Date Diagnosed
High Blood Pressure				Diverticular Disease			
Angina or Chest Pain				Gallbladder Disease			
Heart Failure				Liver Disease			
Irregular Heartbeat				Skin Disease/condition			
Heart Murmur				Anemia			
Blood Clots or Phlebitis				Diabetes			
Stroke or Epilepsy				Thyroid Disease or Goiter			
Parkinson's Disease				Arthritis			
Multiple Sclerosis				Cystitis or Bladder Infections			
Asthma				Prostate Disease			
Chronic Bronchitis				Depression			
Tuberculosis				Mental Illness			
Hiatal Hernia				Dementia or Alzheimer's			
Stomach Ulcer/Reflux				HIV or AIDS			
Chemotherapy				Radiation Therapy			

Do you have?	Y	N		Do you Have?	Y	N
Dentures				Hearing Aid		
Glasses				Pacemaker		

Artificial joints			Where?
Prosthesis			Where?
Are you on a special diet?			What kind?

Women Only		
Are you Pregnant?	Y	N
Have you ever used Estrogen?	Y	N
Have you reached menopause?	Y	N
Date of last menstrual cycle.		
Age of first menstrual cycle.		
Age of menopause.		
Date of last Pap Smear.		

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Social & Surgical History

Patient Name: _____ DOB: _____

Social History						
Do you use tobacco?	y	N	If Yes, what kind?			
Did you ever use tobacco?	Y	N	If yes, what kind?			
What age did you start using tobacco?			How much?	What age did you stop?		
Do you use Alcohol?	Y	N	Did you ever drink alcohol?	Y	N	
If Yes what type?			How Much?			
What age did you start using alcohol?			What age did you stop?			
Do you use illegal drugs?	Y	N	If so, what kind?			
Have you ever used drugs?	Y	N	Is so, What kind?			

Past Surgical History		
Surgery	**Year**	**Hospital and Physician**

Do you have a living Will?	Y	N
If no, would you like information?	Y	N

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Medication History

Patient Name: _____ DOB: _____

Please list all medication prescribed and over the counter medications	
Medication Name:	Dosage:

Are you Allergic to Latex?	Y	N
Are you Allergic to Contrast Dye?	Y	N

Please list Medication Allergies	
Medication	Reaction

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Family History

Patient Name: _____ DOB: _____

Family History					
Is your Mother living?	Y	N	If yes, what is her age?		
If deceased, age, and cause of death.					
Is your Father living?	Y	N	If yes, what is his age?		
If deceased, age, and cause of death.					

List Family members who have had cancer and list type of cancer		
Mother's family	**Father's family**	**Immediate family**

Please list Family Members and check the Appropriate box if there is a history of the following disease(s)

Family Member	Heart Disease	Hypertension	Stroke	Diabetes

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Family History

Patient Name: _____ DOB: _____

Have any of your Family Members been Diagnosed with any of the Following				
	Y	**N**	**Maternal**	**Paternal**
Breast Cancer before age 50				
Ovarian Cancer at any age				
Two Breast Cancers, or Breast and Ovarian Cancer				
Male Breast Cancer				
Colon Cancer				
Uterine Cancer				
10 or more colon polyps in on exam				
Other Cancers				

If any YES boxes are checked under the hereditary cancer risk assessment section, you have a personal or family history suggestive of one of the more common hereditary cancer syndromes and are a candidate for further risk assessment and, if appropriate, genetic testing to determine if a gene change exists. We will discuss this with you and provide you with additional information

Hereditary Cancer Risk Assessment: Have you ever been diagnosed with the following?					
	Y	**N**		**Y**	**N**
Breast Cancer before age 50			Two Breast Cancers, or Breast and ovarian cancer		
Ovarian Cancer at any age			Male Breast Cancer at any age		
Colon Cancer before age 50			Two or more Colon Cancers		
Uterine Cancer			10 or more Colon Polyps found in one or more exams		
Any other cancer					

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Review of Systems

Patient Name: _____ DOB: _____

Review of Systems (Check All that Currently Apply)								
My current state of health is			Excellent __	Good __	Fair __	Poor __		
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain any Yes answers below**		
Weight Loss			Night Sweats					
Loss of Appetite			Weakness					
Severe Fatigue			Dizziness					
Fever			Chills					
Skin								
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain any Yes answers below**		
Itching			Scaling					
Growths			rash					
Hematology								
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain any Yes answers below**		
Excessive Bruising			Excessive Bleeding					
Swollen Lymph Glands								
Ear, Nose, Throat								
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain any Yes answers below**		
Mouth Sores			Frequent sore throat					
Sinus Problems			Hoarseness					
Ringing in Ears			Dental Problems					
Eyes								
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain any Yes answers below**		
Poor Vision			Blurred Vision					
Glaucoma			Double Vision					
Excessive Tearing			Cataracts					

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Review of Systems

Patient Name: _____ DOB: _____

Men Only					
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**
Sexual Difficulty			Hernia		
Prior PSA level			Testicular Mass		
STD(s)			Penile Discharge or sores		

Breast								
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain and Yes answers**		
Lump or mass			Pain in Breast					
Change in size			Discharge from Nipple					
Mammogram			Date of Mammogram					

Women Only						
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain and Yes answers**
Unusual Vaginal Bleeding			Painful intercourse			
Unusual Vaginal Discharge			STD(s)			
Men and Women						
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain and Yes answers**
Are you sexually active?			Have you takes hormones?			

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Review of Systems

Patient Name: _____ DOB: _____

Neurologic/Psychiatric						
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain and Yes answers**
Numbness/Tingling			Difficulty Speaking			
Inability to move			Depression			
Difficulty writing			Frequent Headaches			
Relationship problems			Tremors/Shaking			
Memory difficulty			Personality Changes			
Difficulty Concentrating			Hallucinations			
Gastrointestinal						
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain and Yes answers**
Nausea/Upset stomach			Spitting up/vomiting blood			
Vomiting			Black/Tarry Stool			
Blood in stool			Change in size of stool			
Change in size of stool			Constipation			
Diarrhea			Jaundice			
Difficulty Swallowing			Colonoscopy			Date:
Cardiovascular						
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain and Yes answers**
Chest pain or pressure			Must sleep sitting up			
Fainting Spells			Swelling in feet			
Shortness of Breath			Leg pain or cramping			
Respiratory						
Symptom	**Y**	**N**	**Symptom**	**Y**	**N**	**Explain and Yes answers**
Shortness of breath upon exertion			Shortness of breath at rest			
Wheezing			Coughing up blood			
Frequent infections			Coughing up sputum			
pneumonia vaccine			Influenza vaccine			

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Authorization to Release Medical Records

I hereby request a copy of my current medical records to be sent to Cancer Center of Middle Georgia, LLC at the below address.

Please include:

1. Most recent dictation _____
2. Pathology reports _____
3. Most recent labs _____
4. Radiology reports including a CD if available _____
5. Other _____

Patient Name: _____

Social Security number: _____

Signature: _____

Date: _____

This authorization will remain valid unless revoked in writing by the patient's Signature.

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Patient Financial Policy

Cancer Center Of Middle Georgia is dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as part of your care and treatment. If you have any questions regarding these policies, please discuss with our financial counselor.

Co-payments and patient balances are due at the time of service. For your convenience we accept cash, checks or credit cards.

Insurance

- We have made prior arrangements with insurance and health plans to accept an assignmentr of benefits. This means that we will bill those plans for which we have an agreement and will reqwuire you tyo pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrice for your appointment.
- If you have Midicare PART B only, you are responsible for your Medicare deductible and your 20% of charges at the time of service.
- If you have Insurance coverage with a plan for which we do not have a price agreement. We will prepare and send the claim fo ryou on an unaasigned basis. This means that your insureer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- Your insurance company may require a referral from another physician and or a preauthorization. While it is your responsisbility to obtain a referral, someone in our office will octain/coordinate the necessary pre-authorization prior to your treatments/procedures. Please be aware that while a referral and or pre-authorization may be required by your insurance company, having a referral/pre-authorization does not guarantee payment by you r insuance company and the balance will be your respoinsibility.
    - Please not some authorizations from insurance sompanies can take longer than anticipated and appointments may need to be rescheduled until authorization process is complete and approved.
- In the event your helth plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided by Cancer Center of Middle GFeorgia. Any balance due is you rresponisbility and is die up receipt of a stament from our office.
- Patients who have insurance plans which have deductibles and Coinsurance, please be aware that prior to any treatments you will be responsible for any deductible or coinsurance that may apply. Our financial counselor will make you aware of what type of payments will be necessary and explain this to you.
- Self pay accounts are for patients without insurance coverage, it may also include insurance plans in which Cancer Center of Middle Georgia does not participate. It is your responsibility to know if Cancer Center of Middle Georgia or our providers is participating in your insurance plan. If there is a discrepancy with our information, you will be considered self pay until you provide information otherwise. Self pay patients required to pay each appointment. An estimation of charges will provided do you by our financial counselor.

Past Due Accounts

- If your account becomes past due, any upcoming appointments may need to be postpone into your account is made current.
    - if payment arrangements have been made with Cancer Center of middle Georgia and a scheduled payment been missed you will receive a customary call from our billing Department in a letter concerning your delinquent account in order to arrange payment.
    - If two consecutive scheduled payments have been missed a certified letter will be sent notifying your account has been referred to a collection agency.
    - If your account has been re ferd to a collection agency you must pay the balance in full including any collection fees, before an appointment will be scheduled.

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Patient Authorization, Acknowledgement & Agreement Financial Policy

I hereby authorize payment of health insurance benefits directly to Cancer Center of middle Georgia for services provided to me. I authorize the release of any of my health care information necessary to process my claims. I further authorized the release of my health care information to other health care providers, hospitals and facilities involved in my treatment

I understand, acknowledge and agree that I am financially responsible for my deductible, Co pay an any amount exceeding what my insurance company pays, except where exempt by contractual agreement, I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals an pre authorizations.

I have read the above patient Financial Policy and/or it has been fully explained to me. I certify that I understand its content and that I am competent to execute it or that I am authorized to execute it on the patient's behalf.

Print Patient's Name: _____ Date: _____

Signature: _____

If Legal Representative, provide relationship to Patient: _____

Witness Signature: _____

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Patient rights

As a Patient, you have the right to . . .

- Considerate and respectful care provided in a safe environment, free from all forms of abuse, harassment, or discrimination.
- Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to request an or refuse treatment.
- Be well informed about your illness, possible treatments, and likely outcomes of care (including unanticipated outcomes) and to discuss this information with your doctor. In an emergency, when you lack decision making capacity and the need for treatment is urgent, the information is made available to another person on your behalf.
- Have an advance directive (such as health care proxy, organ donation or living will) and the expectation that we will honor the intent of the directive to the extent permitted by law in hospital policy.
- upon your request, have a family member, chosen representative Ann or your own physician notify promptly of your admission to the hospital.

Patient Responsibilities

Health care providers and organizations are entitled to reasonable and responsible behavior on the part of the patient and his/her family. Such responsibilities may include, but not limited to the following:

- Report perceived risk in your care and unexpected changes in your condition to the person in charge of your care.
- Follow the treatment plan recommended by your doctor. This may include following the instructions of nurses and other health care personnel who carry out doctors' orders and or plan of care.
- Notify your provider if you are unable to keep appointments.
- Provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications, and other matters concerning your health.
- Ask questions whenever you do not understand the information or instructions being provided.

I have received and reviewed a copy of the Patient's Rights and Responsibilities form.

Patient Name _____

Patient Signature: _____ **Date:** _____

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PLEASE NOTIFY US OF ANY INSURANCE CHANGES INCLUDING PHARMACY BENEFITS

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PLEASE BRING IN MEDICATIONS LIST AND ALL MEDICATIONS

INCLUDING ALL PRESCRIBED MEDICATIONS, SUPPLEMENTS/VITAMINS, HERBAL/ESSENTIAL OILS, AND OVER THE COUNTER MEDICINES

TO ALL YOUR OFFICE VISITS

PLEASE NOTIFY YOUR MEDICAL ASSISTANT OF ANY CHANGES TO YOUR MEDICATIONS

THANK YOU, CCMG STAFF

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