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## TENNESSEE CANCER SPECIALISTS

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Patient Appointment \_\_\_\_\_ Time \_\_\_\_\_ Physician \_\_\_\_\_

Dear Patient,

Welcome to Tennessee Cancer Specialists. Our physicians specialize in the care and treatment of both hematology and oncology diagnoses, and our mission is to provide the highest quality of compassionate care to each of our patients. Your physician has referred you to our practice for consultation. We have enclosed several forms that we ask you to complete and bring to your first visit. Completing these forms in advance will help save you time during the check-in process. We will also need you to bring the following with you to your visit:

- The included forms completely filled out
- All medical and pharmacy insurance cards and information
- A driver's license or any form of a photo ID
- Your actual medication bottles (*not just a list*) of the medications you are currently taking
- Any co-pay that is required by your insurance company at the time of your visit
- Copy of living will or power of attorney
- Copy of your Covid-19 Vaccination Card (If you received the vaccine)

We also ask that you try to arrive at least thirty minutes prior to your scheduled appointment time so that we can process your information and answer any questions you might have regarding our facility. NO fasting labs are required for your initial visit with our office. It is very important that you keep your appointment. If for any reason you are unable to keep your appointment, please call as soon as possible so we may reschedule you in a timely manner. Your cooperation is greatly appreciated.

Our clinic hours vary by location, so please ask your Tennessee Cancer Specialists staff about the business hours of your clinic. There will always be medical personnel available after hours and on weekends for any emergency that may arise. Be assured that no matter whom you are treated by during non-office hours, the continuity of your care is always maintained under the direct supervision of your personal physician.

Our goal is always to provide you with professional and courteous service. We look forward to meeting and assisting you with all of your healthcare needs. Thank you for choosing Tennessee Cancer Specialists.

Sincerely,

Your physicians and staff at Tennessee Cancer Specialists

Administrative Office: 900 East Hill Ave., Suite 230, Knoxville, TN, 37915  
Phone: 865-862-0998 Fax 865-544-1861  
[www.tncancer.com](http://www.tncancer.com)

For TCS use only: **Appt. Date and Time:** \_\_\_\_\_ **Account #** \_\_\_\_\_ **Physician** \_\_\_\_\_

**Tennessee Cancer Specialists**

**Patient Information**

How did you hear about our practice? \_\_\_\_\_

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

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

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: (circle): M F

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work/Cell: ( ) \_\_\_\_\_ May we leave a message on this number? Y N

Employer: \_\_\_\_\_ Employer Phone Number: ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Physician That Referred You to TCS: \_\_\_\_\_

Primary Language (circle): English Spanish Other \_\_\_\_\_ Marital Status (circle): M S W D

Ethnicity (circle): Caucasian Hispanic Black Unknown Other: \_\_\_\_\_

Race (circle): White Hispanic or Latino African American Asian Other: \_\_\_\_\_

**Emergency Contact Information**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have a living will? Yes \_\_\_ No \_\_\_

Do you have a medical power of attorney? Yes \_\_\_ No \_\_\_

Do you have a DNR? Yes \_\_\_ No \_\_\_

**Insurance Information**

**Primary Insurance**

Insurance Co. \_\_\_\_\_

Insurance ID # \_\_\_\_\_

Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

**Secondary Insurance**

Insurance Co. \_\_\_\_\_

Insurance ID # \_\_\_\_\_

Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

**Pharmacy Insurance**

Insurance Co. \_\_\_\_\_

Insurance ID # \_\_\_\_\_

Group # \_\_\_\_\_ Effective Date \_\_\_\_\_

**One Time Authorization \*\*\*Please Initial All Four Lines\*\*\***

I authorize the release of any medical information necessary to process insurance claims filed on my behalf \_\_\_\_\_

I authorize payment of medical benefits to be made directly to the supplier or physician for services performed \_\_\_\_\_

I acknowledge that I will be responsible for any balance after insurance(s) has paid \_\_\_\_\_

I understand that it is my responsibility to notify the office of any changes or deletions to my insurance(s) policy \_\_\_\_\_

**HIPAA OMNIBUS RULE**

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Tennessee Cancer Specialists, through its individual physicians, employees, and or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by Tennessee Cancer Specialists.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Tennessee Cancer Specialists.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Tennessee Cancer Specialists. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by any physician and that the results of all tests will be kept confidential.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

**X** \_\_\_\_\_  
Please print name of Patient

**X** \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Legal Representative / Guardian

\_\_\_\_\_  
Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:  
(This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation     Home Phone Confirmation     Work Phone Confirmation  
 **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation     Home Phone Confirmation     Work Phone Confirmation  
 **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- Phone Message     Email     **Either**     **None** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment     I could not communicate with the patient     The patient refused to sign  
 The patient was unable to sign because     Other (please describe) \_\_\_\_\_

Signature of Privacy Officer: \_\_\_\_\_

## New Patient Medical History Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reason for Referral:** \_\_\_\_\_

<b>Allergies:</b>	<b>Type of Reaction:</b>
_____	_____
_____	_____
_____	_____

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

<b>Current Medications and Supplements:</b>	<b>Strength:</b>	<b>How Often Taken:</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Past Medical History (Check all that apply):**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Atrial Fibrillation     | <input type="checkbox"/> COPD                          | <input type="checkbox"/> Gallstones         |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Reflux Disease                | <input type="checkbox"/> Hyperlipidemia     |
| <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Thyroid Disease         | <input type="checkbox"/> Kidney Stones                 | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Peripheral Neuropathy    | <input type="checkbox"/> Seizure                 | <input type="checkbox"/> Stroke                        | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Cancer (please specify) _____ |   |
| <input type="checkbox"/> Arthritis                |  |  |   |

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Past Surgical History - List all prior surgeries and date of occurrence:**

_____	_____
_____	_____
_____	_____

**GYN History:**

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Age at first birth \_\_\_\_\_  
 Age at first period \_\_\_\_\_ Date of last period (mm/dd/yyyy) \_\_\_\_\_  
 Any Hormone use? \_\_\_\_\_ If yes, for contraception or post-menopausal? \_\_\_\_\_ How many years? \_\_\_\_\_  
 \_\_\_\_\_ Last Mammogram (mm/dd/yyyy) \_\_\_\_\_ Last PAP (mm/dd/yyyy) \_\_\_\_\_

**Social History**

Marital Status: (Circle One)      Single      Married      Divorced      Widowed

Occupation: \_\_\_\_\_

**Tobacco Use:**    \_\_\_\_\_ **Never**

\_\_\_\_\_ **Yes, but quit**

How long did you smoke? \_\_\_\_\_

What form of tobacco did you use? Please mark all that apply:

\_\_\_ Cigarettes    \_\_\_ Cigars      \_\_\_ Chewing Tobacco    \_\_\_ Pipe      \_\_\_ Snuff

How many packs per day? \_\_\_\_\_

When did you quit? \_\_\_\_\_

\_\_\_\_\_ **Yes, Active**

How long have you smoked? \_\_\_\_\_

What form of tobacco do you use? Please mark all that apply:

\_\_\_ Cigarettes    \_\_\_ Cigars      \_\_\_ Chewing Tobacco    \_\_\_ Pipe      \_\_\_ Snuff

How many packs per day? \_\_\_\_\_

**Alcohol Use:**    \_\_\_\_\_ **Never**

\_\_\_\_\_ **Yes, Occasional**

\_\_\_\_\_ **Yes, Active**

How many days per week do you drink? \_\_\_\_\_

How many drinks per day? \_\_\_\_\_

\_\_\_\_\_ **Yes, but quit**

How many days per week do you drink? \_\_\_\_\_

How many drinks per day? \_\_\_\_\_

How many years since you quit? \_\_\_\_\_

Have you ever used any recreational or illicit drugs?    \_\_\_ Yes      \_\_\_ No

**Hazardous Materials: Check if you have been exposed to any of the following:**

\_\_\_\_\_ Asbestos      \_\_\_\_\_ Benzene      \_\_\_\_\_ Lead      \_\_\_\_\_ Radiation

\_\_\_\_\_ Other Petroleum Products      \_\_\_\_\_ Other (please specify): \_\_\_\_\_

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

**Family History**

**Please list any major medical problems and/or causes of death in your immediate family:**

<b>Family Member</b>		<b>Current Age</b>	<b>Age at Death</b>	<b>Major Medical Problems</b>
Mother:	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Maternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Maternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Paternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Paternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	_____	_____	_____
Brother	<input type="checkbox"/> Alive	_____	_____	_____
Sister (circle)	<input type="checkbox"/> Deceased	_____	_____	_____
Brother	<input type="checkbox"/> Alive	_____	_____	_____
Sister (circle)	<input type="checkbox"/> Deceased	_____	_____	_____

**Use back if additional room needed.**

**Children / Age(s)** \_\_\_\_\_

Any major medical problems? \_\_\_\_\_  
\_\_\_\_\_

Any additional information that your doctor may need to know:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

Date: \_\_\_\_\_  
Date of visit

Date: \_\_\_\_\_

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

**New Patient Review Of Systems**Chief Complaint: Why are you here **today**? \_\_\_\_\_Have you had a **Flu shot** this year? (circle one) YES NOHave you had a **COVID-19 vaccine**? (circle one) YES NO

Have you had a pneumococcal vaccine? (circle one) YES NO If yes, when? \_\_\_\_\_

Have you had any recent **CT scans, MRI's, PET scans, X-Rays, ER Visits**, etc.? (circle one) YES NOHave you had a **Colonoscopy** or a Flexible Sigmoidoscopy before? (circle one) YES NO If yes, when? \_\_\_\_\_

Have you received hospice care in the last 60 days? (circle one) YES NO If yes, when? \_\_\_\_\_

**Please mark if you are having any of the following symptoms:**

<p><b><u>Constitutional</u></b></p> <input type="checkbox"/> Appetite Good <input type="checkbox"/> Appetite Poor <input type="checkbox"/> Fatigue <input type="checkbox"/> Night Sweats <input type="checkbox"/> Rigors/Chills <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> >10 lbs <input type="checkbox"/> <10 lbs <input type="checkbox"/> Weakness <input type="checkbox"/> Sleep Disturbance	<p><b><u>Eyes</u></b></p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain	<p><b><u>ENMT</u></b></p> <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Ear Pain <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Oral Bleeding <input type="checkbox"/> Sinusitis <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Altered Taste <input type="checkbox"/> Ringing In Ears	<p><b><u>Endocrine</u></b></p> <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Cold Intolerance
<p><b><u>Hematologic/Lymphatic</u></b></p> <input type="checkbox"/> Prolonged Bleeding or Bruising <input type="checkbox"/> Swollen Lymph Nodes or Glands	<p><b><u>Breast</u></b></p> <input type="checkbox"/> Breast Mass L or R <input type="checkbox"/> Breast Pain L or R <input type="checkbox"/> Nipple Discharge L or R <input type="checkbox"/> Skin Changes L or R	<p><b><u>Respiratory</u></b></p> <input type="checkbox"/> Dry Cough <input type="checkbox"/> Productive Cough <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> At Rest <input type="checkbox"/> With Activity <input type="checkbox"/> Coughing Up Blood <input type="checkbox"/> Hiccups <input type="checkbox"/> Wheezing	<p><b><u>Cardiovascular</u></b></p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg or Ankle Swelling <input type="checkbox"/> Left <input type="checkbox"/> Right
<p><b><u>Gastrointestinal</u></b></p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Blood in Stool	<p><b><u>Genitourinary</u></b></p> <p><b><u>Female</u></b></p> <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequency-Increased Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urine Color Change <input type="checkbox"/> Vaginal Discharge/Bleeding	<p><b><u>Genitourinary</u></b></p> <p><b><u>Male</u></b></p> <input type="checkbox"/> Painful Urination <input type="checkbox"/> Frequency-Increased Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urine Color Change	<p><b><u>Musculoskeletal</u></b></p> <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Bone Pain
<p><b><u>Integumentary</u></b></p> <input type="checkbox"/> Blisters <input type="checkbox"/> Dry Skin <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Hair Loss	<p><b><u>Neurologic</u></b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Insomnia <input type="checkbox"/> Memory loss <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness/Tingling	<p><b><u>Psychiatric</u></b></p> <input type="checkbox"/> Hallucinations <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety	<p><b>Are you having any pain today? Please check:</b></p> <p>___ 0 (no pain)</p> <p>___ 1                    ___ 6</p> <p>___ 2                    ___ 7</p> <p>___ 3                    ___ 8</p> <p>___ 4                    ___ 9</p> <p>___ 5                    ___ 10</p> <p><b>Location</b> _____</p>