David A. Diamond, M.D.
Board Certified Radiation Oncologist
Kelly E. LaFave, M.D.
Board Certified Radiation Oncologist

FLORIDA RADIATION ONCOLOGY
WINTER PARK

NEW PATIENT FORMS

(Please Print. Thank You.)

Patient Name: _____ **Date of birth:** _____

Address: _____ **Social Security Number:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

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

Email Address: _____

Alternate Address: _____

City: _____ **State:** _____ **Zip Code:** _____

EMERGENCY CONTACT (PARENT/GUARDIAN IF PATIENT IS A MINOR)
Person we contact if we are unable to reach you

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Power of Attorney (if applicable): _____ **Relation to You:** _____

Living Will: ☐ **Yes** ☐ **No** *Please provide a copy for your record

I certify that the information I will give today is to the best of my ability and as fully accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
PATIENT LEGAL GUARDIAN/REPRESENTATIVE OR PARENT **DATE**

INSURANCE:

Primary Insurance Carrier: _____

Policy ID: _____ Policy Group #: _____

Name of primary policy holder (If not patient): _____

Policy holder's Date of Birth: _____ **Does plan have prescription coverage?** ☐ Yes ☐ No

Secondary Insurance Carrier: _____

Policy ID: _____ Policy Group #: _____

Name of secondary policy holder (If not patient): _____

Policy holder's Date of Birth: _____ **Does plan have prescription coverage?** ☐ Yes ☐ No

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Retired **Retired Date:** _____

Employer (Former if Retired): _____

Occupation (Former if Retired): _____

CLINICAL INFORMATION:

Primary Care Physician: _____ **Phone #:** _____

Referring Physician: _____ **Phone #:** _____

Please list any additional Physicians you see -	Specialty -	Phone #

PREFERED PHARMACY AND LABORATORY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

Where do you normally get your lab work done at?

☐ LabCorp ☐ Quest ☐ Other: _____

Patient Initial _____

REASON FOR THIS VISIT: _____

_____

CANCER HISTORY:

Type: _____ **Date Diagnosed:** _____

Previous Radiation Therapy: ☐ Yes ☐ No Treatment Physician: _____

Treatment Facility: _____ Treatment Date: _____

Previous Chemotherapy: ☐ Yes ☐ No Treatment Physician: _____

Treatment Facility: _____ Treatment Date: _____

Previous Cancer Surgery: ☐ Yes ☐ No Surgeon: _____

Surgery Facility: _____ Surgery Date: _____

Recent Biopsy:

Type: _____ Date: _____ Location: _____

Type: _____ Date: _____ Location: _____

Recent Diagnostic Scans:

Type: _____ Date: _____ Location: _____

Type: _____ Date: _____ Location: _____

Type: _____ Date: _____ Location: _____

PAST SURGICAL HISTORY:

Pacemaker Placement: ☐ Yes ☐ No Date placed: _____

Cardiologist who placed the device: _____

Manufacturer: _____ Last Pacer Check: _____

Managing Cardiologist (if different): _____

Other Stimulator Type: _____ Placement Date: _____

Patient Initial _____

Port Placement	Date:_____	Coronary Bypass	Date:_____
Mastectomy	Date:_____	Angioplasty	Date:_____
Lumpectomy	Date:_____	Cardiac Valve surgery	Date:_____
Hysterectomy	Date:_____	Rotator Cuff Repair	Date:_____
Oophorectomy	Date:_____	Knee Replacement	Date:_____
Tubal ligation	Date:_____	Hip Replacement	Date:_____
TURP	Date:_____	Cataract	Date:_____
Prostatectomy	Date:_____	Gallbladder surgery	Date:_____
Focal Laser Ablation	Date:_____	Hemorrhoidectomy	Date:_____
HIFU	Date:_____	Hernia Repair	Date:_____
Vasectomy	Date:_____	Appendectomy	Date:_____
Thyroidectomy	Date:_____	Tonsillectomy	Date:_____

Other Operations:

_____

_____

MEDICAL HISTORY: (Check the items that apply to you, currently or in the past)

- ☐ None
- ☐ Cancer
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blood Disorder
- ☐ Frequent infections
- ☐ HIV / AIDS
- ☐ Diabetes
- ☐ Thyroid Disease
  - ☐ Hypothyroid (Low)
  - ☐ Hyperthyroid (High)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Heart Attack-MI
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Heartburn / Reflux
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Peripheral Vascular Disease
- ☐ Chronic Lung (COPD)
- ☐ Pneumonia/Bronchitis
- ☐ TB (Tuberculosis)
- ☐ Sleep Apnea
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Ulcers
- ☐ GERD/Heartburn/Reflux
- ☐ Hiatal Hernia
- ☐ Gallstones
- ☐ Cirrhosis of Liver
- ☐ Hepatitis A /B / C
- ☐ Pancreatitis
- ☐ Freq. Urinary Tract infection
- ☐ Kidney Stone
- ☐ Kidney Disease/Failure
- ☐ Enlarged Prostate
- ☐ Osteoarthritis
- ☐ Chronic Back Pain
- ☐ Osteoporosis
- ☐ Fracture
- ☐ Stroke
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Paralysis
- ☐ Seizures
- ☐ Migraines
- ☐ Claustrophobia
- ☐ Autoimmune
  - ☐ Rheumatoid Arthritis
  - ☐ Lupus
  - ☐ Scleroderma
  - ☐ Fibromyalgia
  - ☐ Raynaud's Syndrome
  - ☐ Myasthenia Gravis
  - ☐ Psoriasis
  - ☐ Multiple Sclerosis
- ☐ Shingles
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Hearing Loss
- ☐ Anxiety
- ☐ Depression
- ☐ Drug Use
- ☐ Problems w/Anesthesia
- ☐ Keloid History
- ☐ Dementia
- ☐ Other Medical Conditions

_____

Patient Initial _____

HEALTH MAINTENANCE:

Sigmoidoscopy / Colonoscopy Date: _____ Findings: _____

Last Mammogram Date: _____ Findings: _____

Last Pelvic Exam Date: _____ Findings: _____

Last Bone Density Date: _____ Findings: _____

Last EGD Date: _____ Findings: _____

MEDICATION LIST: Your treatment can be affected by any medication that you take. It is important that your physician has updated and correct information.

List **ALL** medications (including non-prescription) that you are currently taking:

Medication	Dose/Frequency	Reason	Ordering Physician

ALLERGIES: List all medication allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Are you allergic to:

☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye / IV Contrast ☐ Eggs ☐ Peanuts

Other: _____

Type of reaction: _____

Patient Initial _____

SOCIAL HISTORY:

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

Children: ☐ Yes ☐ No Number of Children: _____

Tobacco Use: (Present &/or Past)

☐ **Never Smoked**

☐ **Quit Smoking When?** _____ **How many years did you smoke?** ____yr(s) **How many packs?** ___/day

☐ **Currently Smoke** ☐ **Cigarettes** ☐ **Pipe** ☐ **Cigars** ☐ **Chewing Tobacco** ☐ **Vape**

Alcohol Use:

☐ **Non Drinker**

☐ **Beer** number of bottles _____ per ☐ **Day** ☐ **Week** ☐ **Month**

☐ **Wine** number of glasses _____ per ☐ **Day** ☐ **Week** ☐ **Month**

☐ **Liquor** number of glasses _____ per ☐ **Day** ☐ **Week** ☐ **Month**

Military History:

Have you ever served in the military? ☐ Yes ☐ No Years in service: _____

Service branch and duties: _____

Agent Orange Exposure ☐ Yes ☐ No

Patient Initial _____

FAMILY MEDICAL HISTORY: (Indicate any family members with cancer)

Relation	Age at Cancer Diagnosis	Cancer History	If deceased, Age and cause of death
Father			
Mother			
Siblings			
Children			
Paternal Aunts			
Maternal Aunts			
Paternal Uncles			
Maternal Uncles			
Paternal Grandparents			
Maternal Grandparents			

Other Extended Family (Blood Relative) with cancer: _____

_____

In your opinion, are there any diseases that run in your family? ☐ Yes ☐ No

Please list: _____

REVIEW OF SYSTEMS: (Please check any **current** symptoms you have.)

Patient Initial _____

General:
- ☐ Weight loss
  - How much_____
  - Time frame _____
- ☐ Fevers
  - Max temp _____
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

Eyes:
- ☐ Wear Glasses
- ☐ Contact Lenses
- ☐ Blurred Vision
- ☐ Double Vision

Ears, Nose, Throat:
- ☐ Hard of hearing or deaf
- ☐ Ringing in ears
- ☐ Enlarged lymph nodes
- ☐ Chronic sinus problems
- ☐ Sore throat
- ☐ Mouth pain/sores

Changes/Difficulty In:
- ☐ Taste
- ☐ Smell
- ☐ Voice

Cardiovascular:
- ☐ Chest pain/Angina Pectoris
- ☐ Palpitations/heart murmur
- ☐ Irregular heart beat pressure

Respiratory:
- ☐ Chronic or Frequent Cough
- ☐ Bloody Sputum
- ☐ Shortness of breath

Gastrointestinal:
- ☐ Difficult or painful swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Lump or sensation in throat
- ☐ Food Sticking
- ☐ Bloating
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Black or tarry stools
- ☐ Blood in stool
- ☐ Excessive rectal gas/flatus
- ☐ Loss of stool/fecal accident
- ☐ Poor appetite
- ☐ Jaundice

Genitourinary:
- ☐ Kidney Stones
- ☐ Pelvic Pain
- ☐ Incontinence
- ☐ Burning or pain in urination
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Men: Prostate problems

Musculoskeletal:
- ☐ Joint Pain/Arthritis
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle aches

Neurologic:
- ☐ Numbness, tingling
- ☐ Arm or leg weakness
- ☐ Light-headed, dizzy, fainting spells
- ☐ Headache
- ☐ Seizure
- ☐ Speech difficulty
- ☐ Slurred Speech
- ☐ Problem understanding speech
- ☐ Memory Issues
  - ☐ Short-term memory Loss
  - ☐ Long-term memory Loss
- ☐ Confusion
- ☐ Altered mental status
- ☐ Facial Droop
- ☐ Loss of vision

Allergies/Immunology:
- ☐ History of chronic infections
- ☐ History of allergies

Hematologic:
- ☐ Easy bruising
- ☐ Gum or nose bleeding
- ☐ Blood transfusion in the past

Skin:
- ☐ Rashes or itching
- ☐ Change in skin color or moles
- ☐ Varicose vein
- ☐ Skin Cancer

Psychiatric:
- ☐ Anxiety/Agitation
- ☐ Depression
- ☐ Crying for no reason
- ☐ Insomnia
- ☐ Alcoholism
- ☐ Drug Problem (Now/Past)

Endocrine:
- ☐ Heat or cold intolerance
- ☐ Excessive skin dryness
- ☐ Excessive thirst or urination
- ☐ Weight problem
- ☐ Hot flashes

Breast:
- ☐ Breast pain
- ☐ Breast rash
- ☐ Breast mass
- ☐ Change in nipple
- ☐ Nipple discharge

Gynecologic:
- Age at start of menses _____
- Last menstrual period _____
- Age at birth of first child_____
- ☐ Vaginal Bleeding
- ☐ Vaginal discharge
- ☐ Painful Intercourse
- ☐ Pelvic Pain
- ☐ Menstrual irregularity
- ☐ Hormone replacement therapy
  - Use? _____
  - If Yes, How long? _____

Patient Initial _____

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Financial Policy Information

We are please you have chosen Florida Radiation Oncology for your patient services.

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have put together this financial policy sheet.

Commercial Insurance: Florida Radiation Oncology will bill insurance provided; your carrier will make payment directly to our office. In the event your insurance company does not pay for billed services, the balance will be your responsibility. We will verify the insurance coverage and let you know what, if any, percentage you will be responsible to pay. Payment is due on the date of service. **Please notify us of any changes in insurance coverage prior to time of service.**

Medicare & Medicaid: Please be advised that all Medicare/Medicaid claims will be filed through our billing agency. Our doctors are participating physicians and accept Medicare assignment. This means that Medicare will send a check to our office for payment of services rendered. As a courtesy to you, we will submit the co-insurance to your secondary carrier if Medicare had not already done so. These payment deductions will be seen in your monthly statements. If you do not have a secondary carrier, please be advised that Medicare requires us to collect the yearly deductible and the 20% balance on all allowed charges by law.

Insurance Release: I authorize Florida Radiation Oncology to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including; medical, psychiatric, laboratory studies, HIV testing, and other medical data related to my care. I authorize any insurer or payer to make payment directly to Florida Radiation Oncology. A photocopy of this authorization shall be considered as effective and valid for the duration of this claim.

Financial Agreement: I understand that my insurance contract is between me and my insurance company. I also agree that I am responsible for any charges that my insurance company will not cover. Our front desk staff will ask you for payment for any past due balances as well as your portion of the payment for today's service. This includes co-pays, co-insurances and deductibles. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

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Out-of-Network & Self-Paying Patients: As a service to you, we would like to meet with you so that we can arrange a payment plan that would be comfortable for both you and our office. We will be happy to discuss any questions that you might have.

We accept cash, personal check, VISA, MasterCard, Discover, and American Express credit cards. There is a $40.00 service charge for returned checks.

Thank you for your cooperation. We hope this has answered any questions.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature of Patient, Parent or Legal Guardian/Representative Date

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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:

Florida Radiation Oncology
483 N. Semoran Blvd, Ste 107
Winter Park, Florida 32792
Phone 407-539-0722 Fax 407-539-0723

	Item		Item
•	Office Visit Note	•	MRI films and reports
•	Pathology Report	•	Bone scan films and reports
•	Operative Report	•	Lab Results
•	Discharge Summaries	•	Radiation Treatment Records
•	CT scans and reports	•	Simulation/Port Films
Other:			

It is my understanding that by signing this authorization for release of my records, I am giving permission for Florida Radiation Oncology to receive copies of any medical, psychiatric, Aids, Aids relates syndromes, HIV testing, Alcohol and/or drug abuse related information from 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 one (1) year after the date below or sooner at my election.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature Patient, Parent or Legal Guardian/Representative Date

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HIPAA – Others Involved In Health Care

As a patient of Florida Radiation Oncology, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. The information provided on this page will be valid for one year from the date of signature. This information can be changed or revoked with your permission at any time.

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

I give permission for information related to my current health status to be discussed with:

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

Patient Name: _____ **Date of Birth:** _____
Print Name

Signature: _____ **Today's Date:** _____
Patient or Legal Representative