HOPE
CANCER CENTER
OF EAST TEXAS
Expertise. Experience. Compassion. HOPE.

Welcome to HOPE Cancer Center of East Texas, we have a tradition of caring. We are committed to providing our patients with the highest quality and compassionate care.

Appointment Date: _____ ***Appointment Time:*** _____ ***am/pm*** ***Physician:*** _____

Referred By: _____ ***Primary Care Physician:*** _____

Patient Information

Patient Name *(Last, First M.I.)*				Date of Birth / /		Marital Status ☐ S ☐ M ☐ D ☐ W
Street Address		City	State	Zip		County
Home Telephone # ( )	Work Telephone # ( )	Cell Telephone # ( )		E-mail Address		
Sex ☐ M ☐ F	Social Security # - -	Language	Race	Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic		
How did you hear about our practice?		Occupation		Employed ☐ Y ☐ N	Student ☐ Full-time ☐ Part-time	
Name of Employer / School		Employer's Street Address		City	State	Zip
Name of Spouse or Next of Kin	Relationship	Home Telephone # or Work #, if spouse ( )		Cell Telephone # ( )		
Name of Other Contact (Friend or Relative)	Relationship	Home Telephone # ( )		Cell Telephone # ( )		

***** Please complete form in its entirety*****

Insurance Information

Insurance (Primary)

Insurance Company *(Primary)*		Insured's Id. #	Policy Group #	Group / Employer Name		
Name of Insured	Date of Birth / /	Relationship	Insured's Street Address	City	State	Zip
Insured's Telephone #	Insured's Employer Telephone # ( )		Social Security # - -	Sex ☐ M ☐ F	Occupation	
Name of Employer			Employer Street Address	City	State	Zip

Insurance (Secondary)

Insurance Company *(Primary)*		Insured's Id. #	Policy Group #	Group / Employer Name		
Name of Insured	Date of Birth / /	Relationship	Insured's Street Address	City	State	Zip
Insured's Telephone #	Insured's Employer Telephone # ( )		Social Security # - -	Sex ☐ M ☐ F	Occupation	
Name of Employer			Employer Street Address	City	State	Zip

Please note: In order for our office to receive reimbursement from your insurance company according to the contractual terms set by your insurance plan, we request that you inform our office of any insurance changes immediately prior to or upon check-in for your visit and/or services. Failure to notify our office in a timely manner of the appropriate changes will result in the patient and/or guarantor assuming full responsibility of the balance.

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Patient Name: _____ Date of Birth: _____

MEDICAL CONSENT TO TREATMENT

I hereby voluntarily consent to receive medical services at HOPE Cancer Center of East Texas (HOPE) and give authorization and consent of any necessary medical treatment that is provided while under the care of one or more physicians at HOPE. I understand that such services may include examinations, diagnostic procedures, treatment, which may include chemotherapy, etc. Additional ancillary services may be ordered and performed in an effort of properly diagnosing and treating a medical condition and/or part of preventative care. I have the right to refuse specific treatments and/or procedures. I acknowledge that this agreement of "Medical Consent for Treatment" can be revoked by me at any time by written notification and is valid until revoked.

I understand that no warranty or guarantee has been made to me as to result or cure. I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

AUTHORIZATION TO RELEASE INFORMATION

I authorize my insurance carrier(s) to release information regarding my coverage to HOPE Cancer Center of East Texas (HOPE). I also authorize agents of any hospital, treatment center, physician, etc. to furnish HOPE copies of any records of my medical history, services and/or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to the review of my records for purposes of internal audits, research and quality assurance reviews within HOPE.

ASSIGNMENT OF BENEFITS

My right to payment for all procedures, tests, supplies and nursing/physician services including major medical benefits are hereby assigned to HOPE. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plan. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event payments are made directly to me or my representative, I will endorse such payments to HOPE.

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all out-of-pocket amounts identified by my insurance carrier(s) that are due to HOPE, which includes, but not limited to deductible, co-payment and co-insurance amounts. I also understand that I am responsible for services not covered or reimbursed by my insurance carrier(s) or any other third party payer. Additionally, I understand that it is my responsibility to make sure insurance payments are processed and paid promptly. I understand that in order for HOPE to receive reimbursement from my insurance company according to the contractual terms set by my insurance plan, I am to inform HOPE of any demographic changes, i.e. address, telephone number(s), insurance carrier, etc. immediately prior to or upon check-in for my visit and/or services. Failure to notify HOPE in a timely manner of the appropriate changes may result in me and/or the responsible party assuming full responsibility of the balance. I agree that in the event that I do not have insurance or any other third party reimbursement program, that I am fully responsible for payment of services.

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge that I have received a copy of the Patient Rights & Responsibilities in addition to the Patient Policies "A Tradition of Caring", which includes payment & other financial obligations.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of this statement is considered the same as original.

Patient Signature _____ Today's Date/Time _____ AM or PM (*circle)*

Responsible Party Signature _____ Relationship to patient _____ Today's Date/Time _____ AM or PM (*circle*)

PHYSICIAN:		Acct #		LOC		EMPLOYEE INITIALS

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Today's Date: _____ SEND REPORTS TO THE FOLLOWING PHYSICIANS:

Name: _____ Primary physician: _____

Date of Birth: _____ Surgeon: _____

Age: _____ Other Specialists: _____

What are your reasons for coming to see the doctor? _____

What tests have been done, where and by whom (include CT, MRI, bronchososcopy….etc.): _____

List any past surgery, date done and by whom: _____

List all past and present MEDICAL problems and HOSPITALIZATIONS unrelated to surgery (such as diabetes, heart disease, hypertension, emphysema) and date diagnosed:

List any problems you have had with ANESTHESIA in the past:

If you have ever been transfused with any BLOOD products, list when and why:

MEDICATIONS – Please list prescriptions, vitamins, herbals and supplements:

1 _____ 7 _____

2 _____ 8 _____

3 _____ 9 _____

4 _____ 10 _____

5 _____ 11 _____

6 _____ 12 _____

ALLERGIES to medicines: Reaction medicine caused:

FAMILY HISTORY. Check if any family member has had the following and their age when diagnosed:

Breast Cancer _____ Melanoma _____ Colon Cancer _____ Brain Tumors _____

Ovarian Cancer _____ Sickle Cell Disease _____ Lung Cancer _____ Thalassemia _____

Lymphoma _____ Bleeding disorders _____ Leukemia _____ Hemophilia

Clotting disorders (include leg clots such as DVT, pulmonary embolus, strokes): _____

Other cancers _____

List ANY other medical problems with family members. If they have passed away, list their cause of death and at what age:

Mother: _____ Father: _____

Brothers: _____ Sisters: _____

Maternal grandmother: _____ Maternal grandfather: _____

Paternal grandmother: _____ Paternal grandfather: _____

SONS NAME(S)	AGE	PHONE NUMBER

DAUGHTERS NAME(S)	AGE	PHONE NUMBER

SOCIAL HISTORY

With whom do you live? _____ Marital status: _____

How far did you go in school? _____

List present or past employer: _____ Retired? ___ **Yes** ___ **No**

Toxic exposures (Asbestos, Agent Orange, Benzene….etc): _____

Smoker, present or past? ___ Yes ___ No How many years did you smoke? _____

When did you quit smoking? _____ Use other tobacco products? _____

Alcohol intake: _____ If a former drinker, when did you quit? _____

Have you or do you use other "street drugs" such as cocaine, heroin or IV drugs? _____

Do you want to be screened for HIV by a lab test? ___ Yes ___ No

REVIEW OF SYSTEMS – Describe any significant or progressive symptoms over the past few months:

Fever: _____ Weight Change: _____ Night Sweats: _____
SKIN RASHES: _____ Moles changed: _____ Bruising: _____
LYMPH NODES enlarged or sore: _____ What areas? _____
THYROID nodules: _____ Over active (hyperthyroidism): _____ Under active (hypothyroidism): _____

HEAD, EYES, EARS THROAT, SINUSES

Headaches: _____ Visual change: _____
Hearing Loss: _____ Nose Bleeds: _____
Difficulty swallowing: _____ Mouth sores: _____
Dental problems: _____ Condition of teeth/dentures: _____

BREASTS

Mass/nodule: _____ Nipple drainage: _____ Pain: _____
Prior biopsies: _____ Last Mammogram: _____

LUNGS

Cough: _____ Sputum clear, discolored or bloody: _____
Chest pain: _____ Pleurisy: _____ Wheezing: _____ Short of breath: _____
PPD – last done? _____ PPD positive? _____

HEART

Chest heaviness or angina: _____ Murmur: _____
Palpitations: _____ Heart Failure: _____
Last cardiac catheterization and result: _____

GASTROINTESTINAL

Nausea/vomiting: _____ Blood seen: _____
Abdominal pain: _____ Indigestion: _____ Reflux: _____
Food catches when swallowing: _____ Jaundice: _____
Diarrhea: _____ Change in stool caliber: _____ Constipation: _____
Black or tarry stools: _____ Incontinence: _____
Last upper endoscopy: _____ By whom: _____
Last colonoscopy: _____ By whom: _____

GENITOURINARY

Painful urination: _____ Strain to pass urine: _____ Frequent need to void: _____
Nighttime voiding: _____ Blood in urine: _____ Incontinence: _____
Sexually transmitted diseases (HIV/AIDS, Herpes, syphilis…etc): _____

MEN ONLY

Last digital rectal exam: _____ Last PSA blood test and result: _____
Impotence: _____ Interest in medicines for erectile dysfunction? _____

WOMEN ONLY

Could you be pregnant now? _____ Age of 1st menstrual period: _____
Age of last menstrual period: _____ Excessively heavy menses now? _____
Postmenopausal bleeding? _____ Had hysterectomy? _____ Ovaries removed? _____
Number of pregnancies: _____ Number of live births: _____ Age at 1st pregnancy: _____
Did you breast feed your children? _____ Have you ever taken postmenopausal estrogens? _____
If yes, name and for how long: _____ Date stopped: _____
Pain with sexual intercourse? _____ Vaginal dryness: _____
Hot flashes: _____ Date of last pelvic/PAP: _____

PSYCHIATRIC

Have you ever been hospitalized for a psychiatric problem? _____
If yes, please indicate diagnosis and dates: _____
Suicide attempt in the past? _____ Depression: _____ Panic attacks: _____
Claustrophobia: _____ Do you need sedation for an MRI? _____

NEUROLOGY

Weakness: _____ All over? _____ One side only? _____
Numbness or tingling: _____ If yes, what area? _____ Confusion: _____
Memory loss: _____ Difficulty speaking: _____ Imbalance: _____
Need assistance such as cane, walker, wheelchair? _____ Personality or behavior change? _____
Fainting spells: _____ Dizziness related to standing up? _____
Seizures: _____ If yes, age of onset: _____ Tremors or any movement disorder? _____

BONE AND JOINTS

Back pain: _____ Joint pain: _____ Muscle pain or weakness: _____
Last Bone density scan: _____ Result? _____

VACCINATIONS (LIST ONLY MOST RECENT)

Pneumovax: _____ Zostavax: _____ Tetanus: _____ Flu: _____ Hepatitis B: _____

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Family History Questionnaire

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

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then **indicate family relationship** AND **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Example:	***3 or more Breast, Ovarian, or Pancreatic Cancers***	***Sister - breast @ 56***	***Aunt -breast @46 Cousin-ovarian @58***

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	**N**	**1 case** of Breast cancer ***at or under age 45***				
Y	**N**	**2 cases** of Breast cancer - ***one of which is at or under age 50*** *on the same side of the family*				
Y	**N**	Breast cancer in both breasts OR multiple primary breast cancers (***1ST diagnosis at or under age 50***)				
Y	**N**	Ovarian, peritoneal, or fallopian tube cancer ***at any age***				
Y	**N**	Male breast cancer ***at any age***				
Y	**N**	Breast Cancer diagnosis with Triple Negative Receptors: ER-, PR-, and HER2- ***at or under age 60***				
Y	**N**	**3 cases** of: Breast, Ovarian, or Pancreatic cancer at ANY AGE and IN ANY COMBINATION *on the same side of the family*				
Y	**N**	Colorectal cancer diagnosed **under age 50**				
Y	**N**	Endometrial cancer diagnosed **under age 50**				
Y	**N**	**2 cases** of Lynch syndrome related cancers*** *in one person*				
Y	**N**	**3 cases** of Lynch syndrome related cancers*** *on same side of the family*				
Y	**N**	**20 or more** total polyps in the colon *throughout life*				
Y	**N**	**Has anyone in your family had genetic testing for a hereditary cancer syndrome?**				

******Lynch syndrome related cancers – Colorectal, Endometrial, Gastric, Ovarian, Pancreas, Ureter, Renal Pelvis, Biliary Tract, Brain, and Small Intestinal Cancers.***

Patient's Signature:_____ Date: _____