Patient Information

Date ____________________ Social Security Number___________________________

Patient Name (First) _________________ (M.I.) _____ (Last) ____________________

Patient Address ____

Zip Code ___________ City _____________________________ State ____________

Home Phone __________________________ Cell Phone _________________________

Employer ____________________________________ Work phone _______________

Date of Birth _____________________ Sex ________ Marital Status _____________

Nearest Relative (outside home) Name____

Phone_____________________ Relation _____________________________________

Insurance Holder Information or Guarantor Information

Patient Relation *(i.e. self, husband, wife, father, mother)*

Guarantor Name (First) _____________ (M.I.) _____ (Last) _____________________

DOB__________________________ Social Security Number _____________________

Guarantor Address ____

Zip Code ______________ City _______________________________ State _______

Home Phone __________________ **Employer** _________________________________

PAYMENT POLICY

Payment or partial payment is required on the day of visit.

If you have insurance coverage, we ask that you pay the amount the insurance does not cover, such as the deductible and co-insurance. All accounts are to be paid in full within 90 days from date of service. Payment(s) can be made by cash, check, or MasterCard, Visa or Discover. If account is not paid, it will be placed with our collection agency. If a check is returned to us for any reason, a $20.00 service charge will be added to your account.

As a courtesy, our office will file your insurance. Your insurance policy is a contract between you and your insurance company. You are responsible for payment of all services rendered, whether or not your insurance company has paid. It is important to understand that your insurance company may not pay all of the charges and the difference between what they pay and your total charges is your responsibility. Our office can help you with problems which may arise with your claim, but our office does not accept the responsibility for negotiating a settlement on a disputed claim.

I have read the above payment policy and understand that I am responsible for payment of my account. Assignment: I assign and request payment of medical benefits to physician for services.

____ ____________________

Patient/Guardian Signature Date

Primary Care Physician____

Please list physicians other than your referring physician and primary care physician whom you would like to receive a copy of your pathology report.

Name	City/State

Patient Name: ______________________________ **OCC#** ________________

Patient Medical History:
Allergies: ____

Current Medications (or attach list): ______________________________

____

____

____

Personal History of Cancer: (type, physician, year): ____________________

____

Previous Surgeries or Biopsies (type,, year): __________________________

____

____

Important Medical History: ______________________________________

____

____

Social History:

Smoking ☐ Yes ☐ No How many years? ____________ pack/day ____________
When did you quit? ____________
Chew Tobacco ☐ Yes ☐ No How many years? ________ How much? ________
When did you quit? ____________
Alcohol ☐ Yes ☐ No Drinks/day ____________ or drinks/week ____________
When did you quit? ____________
Illicit Drug Use ☐ Yes ☐ No ______________________________
Exposure to toxic chemicals, radiation, toxic materials (circle any that apply).

Birthplace: ______________________________________
Do you work? ☐ Yes ☐ No If yes, occupation: ______________________

Family History of Cancer (mother, father, brother, sister, etc; cancer type):

____

____

____

Dr. Review: ________________

Patient Name: ______________________________ **OCC#** ________________________

Review of Systems

(please check any recent symptoms)

General

☐ Weight loss or gain ☐ Fever or chills ☐ Fatigue

Skin

☐ Rashes ☐ Itching ☐ Dryness

Head

☐ Headache ☐ Head injury

Ears

☐ Decreased hearing ☐ Earache ☐ Drainage

Eyes

☐ Glasses or contacts ☐ Blurry or double vision ☐ Dry eyes

Nose

☐ Stuffiness ☐ Itching ☐ Nosebleeds ☐ Discharge
☐ Hay fever ☐ Sinus pain

Mouth

☐ Bad/sore teeth ☐ Gum disease ☐ Dry mouth
☐ Dentures or Bridges

Throat

☐ Sore tongue ☐ Sore throat ☐ Hoarseness

Neck

☐ Lumps ☐ Pain ☐ Stiffness

Breasts

☐ Lumps ☐ Pain ☐ Nipple discharge ☐ Breastfeeding

Respiratory

☐ Cough ☐ Coughing up blood ☐ Wheezing
☐ Shortness of breath ☐ Painful breathing

PLEASE TURN TO THE OTHER SIDE OF PAGE

Patient Name: ______________________________ **OCC#** ________________________

Review of Systems

(please check any recent symptoms)

Cardiovascular

- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Shortness of breath with activity
- ☐ Swelling (legs/feet, arms/hands)
- ☐ Shortness of breath lying down

Gastrointestinal

☐ Swallowing difficulties ☐ Heartburn ☐ Yellow eyes or skin (jaundice)

Urinary

☐ Blood in urine ☐ Painful urination ☐ Increase frequency

Genital

Male

☐ Sores ☐ Lumps ☐ Abnormal drainage

Female

☐ Itching or rash ☐ Pain ☐ Lumps ☐ Abnormal discharge

Musculoskeletal

☐ Muscle or joint pain ☐ Back pain ☐ Swelling of joints

Neurologic

☐ Seizures ☐ Numbness ☐ Tingling

Hematologic

☐ Ease of bruising ☐ Ease of bleeding

Endocrine

☐ Heat or cold intolerance ☐ Sweating ☐ Diabetes

Psychiatric

☐ Nervousness ☐ Memory loss ☐ Depression

Physician Review: ________________________

Authorization to Release Medical Records/Information

Physician to provide records:____

Patient's name:____

Social Security #:____________________________DOB: ______________________

Person/Facility to receive records: Outpatient Cytopathology Center

Address: 2400 Susannah Street Suite A

City, State, Zip: Johnson City TN 37601

Phone **#:** 423-283-4734 FAX #: 423-283-4736

(Please initial one line)

Release these records: Initials

1. Only records generated by this facility (not including records received from other sources) ________
2. Only some portion of records maintained at this facility (dates of treatment, etc., specify below) ________
3. All medical records at this facility ________

____

Expiration or revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies- A copy of this authorization may be utilized with the same effectiveness as an original.

______________________________	______________________________
Patient name (print):	Person authorized to sign for patient (print):
______________________________	______________________________
Patient's signature	Signature Relationship to patient
Date: ________________________	Date: ________________________

May the OCC staff contact you to provide you with appointment reminders or for the purpose of advancing medical education through clinical and surgical follow ups? Below is a list of persons with whom we have permission to speak to and/or release medical records to on your behalf. Please circle all that apply.

A. Whom may speak with ________________________.

Relation: ________________________

May we release records to this individual? ____ *Yes* ____ *No*

B. Work Number ________________________.

C. Voicemail/Answering Machine.

D. I do not have a telephone number, you may call ________________ and speak with __________________________.

E. Do not call me to confirm appointments or to obtain medical follow up information.

Patient/Guardian name: ____ Date: ____________

Patient/Guardian Signature: _______________________________________

This form is valid until further notice, until modified or replaced at the patient's request.

I have received a copy of the *Notice of Privacy Practices for Protected Health Information* brochure.

Patient/Guardian name: ____ Date: ____________

Patient/Guardian Signature: _______________________________________