

# DR. WODAJO NEW PATIENT FORM

## PATIENT INFO:

PLEASE PRINT

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
M.I.

\_\_\_\_\_  
Today's Date

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M  F

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient Address (street): \_\_\_\_\_

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

E-mail Address: \_\_\_\_\_

Preferred method of contact (circle one) - Home Phone    Mobile Phone    Work Phone    E-mail

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency/Phone: \_\_\_\_\_ Emergency/Alternate Phone: \_\_\_\_\_

## REFERRING DOCTORS:

Referring Doctor First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Orthopedic Doctor First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Radiation Oncologist First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Medical Oncologist First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

## REASON FOR VISIT (please provide details with dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMAGING STUDIES: Please provide name and location where you had your imaging done (you must bring the disk to your appointment. You will be rescheduled if you do not have your disk with you).**

X-Ray: \_\_\_\_\_

CT Scan: \_\_\_\_\_

MRI: \_\_\_\_\_

Bone Scan: \_\_\_\_\_

PET Scan: \_\_\_\_\_

Ultrasound: \_\_\_\_\_

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

# ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

Patient Name: \_\_\_\_\_  
Last First M.I. Today's Date  
 ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Telephone Cell phone

Home Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_  
City State Zip City State Zip

DOB: \_\_\_\_\_ Age \_\_\_\_\_  M  F SS# \_\_\_\_\_  Married  Single  Divorced  Widowed  
Sex

Employer: \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Telephone  
 \_\_\_\_\_  
Address Occupation

Responsible Party: \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Relationship Telephone

Emergency Contact:  
 Spouse/Next of Kin: \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Relationship Telephone

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

- I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
- I authorize my insurance carrier to release information regarding my coverage to Virginia Cancer Specialists, P.C. I also authorize agents of any hospital, treatment center or previous physician to furnish Virginia Cancer Specialists, P.C. copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Virginia Cancer Specialists, P.C.
- My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Virginia Cancer Specialists, P.C. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Virginia Cancer Specialists, P.C.
- I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

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 the statement is considered the same as original.

\_\_\_\_\_  
 Patient Signature Date/Time AM or PM (circle one)

\_\_\_\_\_  
 Responsible Party Signature Relationship Date/Time AM or PM (circle one)

PHYSICIAN _____ ACCT NBR _____ LOC _____ <small>FOR OFFICE USE ONLY</small>	EMPLOYEE INITIALS _____
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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Virginia Cancer Specialists, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Virginia Cancer Specialists.

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

Signature: \_\_\_\_\_

Name of Personal Representative (if appropriate): \_\_\_\_\_

Signature of Personal Representative (if appropriate): \_\_\_\_\_

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

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Virginia Cancer Specialists Use Only

Date acknowledgement received: \_\_\_\_\_

-OR-

Reason acknowledgement was not obtained and employee signature:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# DR. WODAJO NEW PATIENT FORM

**SURGICAL HISTORY:** Please list the following. If you need additional space, it is provided on the last page.  
Surgeries (with dates):

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**ALLERGIES ADVERSE DRUG REACTIONS** (types of reactions, be specific)

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**MEDICATIONS:** Please list all medications, including *prescription, non-prescription, and other (including herbal)* that you are currently taking. Please include *dosage* and *frequency* taken.

Medication	Dosage	Frequency
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

**PHARMACY:** Please list name and address of your preferred local pharmacy:

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

Pharmacy Address: \_\_\_\_\_

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



**MEDICAL CONDITIONS**

Check all that Apply

**Psychological**

- ADD/ADHD
- Anxiety/Depression
- Bipolar Disorder
- Dementia
- Eating Disorder
- OCD
- Post-Traumatic Stress Syndrome

**Communicable/Infectious Disease**

- AIDS/HIV
- Herpes Simplex

**Autoimmune Disorders**

- Rheumatoid Arthritis
- Lupus
- Multiple Sclerosis

**Pulmonary/Respiratory**

- Asthma
- COPD/Emphysema
- Lung Disease
- Sleep Apnea

**Genitourinary**

- Benign Prostatic
- Hypertrophy (BPH)

**Hematological**

- Anemia
- Deep Venous Thrombosis
- Pulmonary Embolism

**Chronic Disease**

- Arthritis
- Fibromyalgia Osteopenia/Osteoporosis
- Past History of Cancer

If Yes, Type of Cancer: \_\_\_\_\_

**Gastro/Intestinal**

- Crohn's/Ulcerative
- Colitis
- Diverticulitis
- GERD/Hiatal Hernia
- Hepatitis A/B/C
- Irritable Bowel Syndrome
- Liver Disease
- Reflux
- Ulcers

**Cardiovascular**

- Collagen Vascular Disease
- Coronary Artery Disease/MI or Angina
- Heart Arrhythmia
- Heart Failure
- High Blood Pressure
- High Cholesterol
- Pacemaker
- Peripheral Vascular Disease
- Stroke

**Endocrine**

- Diabetes
- Thyroid Disorder
- Other Endocrinological Disorder

**Gynecological**

- Dysfunctional Uterine
- Bleeding
- Endometriosis
- Polycystic Ovarian Disease

**Nephrology**

- Kidney Disease
- Kidney Stones

**Neurological**

- Migraines
- Neurological Disorder
- Parkinson's
- Seizures

**Skin**

- Hives
- Eczema
- Psoriasis
- Other

**Other**

- Gout
- Restless Leg Syndrome



# DR. WODAJO NEW PATIENT FORM

**SYMPTOMS:** Please list any symptoms you may have in the past 6 months in the categories below.

## **Constitutional**

- Weight Loss
- Poor Energy Level
- Fever
- Chills
- Night Sweats

## **Eyes**

- Double Vision
- Vision Loss
- Flashing Lights

## **ENT/Mouth**

- Ringing in Ears
- Oral Ulcers
- Nasal Drip
- Hearing Loss
- Bleeding Gums
- Mouth Pain
- Nose Bleeds
- Sore Throat
- Difficulty Swallowing
- Hoarseness
- Sinus Pain

## **Cardiovascular**

- Chest Pain or Pressure upon Exertion
- If yes, explain: \_\_\_\_\_

- Arm/Leg Swelling
- Palpitations
- Calf Discomfort
- Fainting Spells
- Arm Swelling

## **Respiratory**

- Cough
- Wheezing
- Shortness of Breath
- Coughing Blood
- Pain w/Breathing

## **Breast**

- Mass
- Pain
- Nipple Discharge
- Change in Size
- Change in Shape

## **Psychiatric**

- Depression
- Anxiety
- Lack of Concentration

## **Gastrointestinal**

- Vomiting
- Jaundice
- Abdominal Pain
- Maroon/Black Stool
- Constipation
- Abdominal Cramping
- Diarrhea
- Vomiting Blood
- Change in Swallowing
- Nausea

## **Urinary**

- Painful Urination
- Blood in Urine
- Increased Frequency
- Loss of Control
- Impotence

## **Gynecological**

- Vaginal Discharge
- Pelvic Pain
- Vaginal Dryness
- Unexplained or Heavy Bleeding
- If yes, explain: \_\_\_\_\_

## **Musculoskeletal**

- Muscle Pain
- Spine Tenderness
- Swollen Joints
- Joint Redness
- Bone Pain

## **Endocrine**

- Excessive Urine
- Excessive Thirst
- Hot Flashes
- Heat Intolerance
- Cold Intolerance

## **Hematological**

- Nose Bleeds
- Bleeding Gums
- Purple Spots on Hands
- Bruising

## **Neurological**

- Confusion
- Seizures
- Fainting Spells
- Tremors
- Speech Change
- Headache
- Hiccups
- Abnormal Gait Weakness
  - Upper Extremity
  - Left Side
  - Lower Extremity
  - Right Side
- Sensory Change
- Abnormal Numbness/Tingling
- If yes, explain: \_\_\_\_\_

## **Lymphatic**

- Enlarged Lymph Nodes
- Swelling in Arms

## **Skin**

- Rash
- Nodules
- Itchiness
- Lesions
- If yes, explain: \_\_\_\_\_



## HEALTH HISTORY AND PREVENTATIVE HEALTH MAINTENANCE

Please provide dates for each answer or write "none".

Mammogram: \_\_\_\_\_

Bone Density Scan: \_\_\_\_\_

Colonoscopy: \_\_\_\_\_

Pneumonia Vaccine: \_\_\_\_\_

Have you had a flu vaccine this flu season (Sept-March)?:  Y  N

Have you ever had a blood transfusion?  Y  N, If yes, when? \_\_\_\_\_

## SOCIAL & ENVIRONMENTAL REVIEW (If Yes, please fill out type, quantity, how often, etc...)

Do you drink alcoholic beverages:  Y  N

How many drinks per week/month: \_\_\_\_\_

Have you ever smoked cigarettes?  Y  N

Are you currently smoking?  Y  N

Packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

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

Do you use recreational drugs?  Y  N

How often? \_\_\_\_\_ How much? \_\_\_\_\_

What type? \_\_\_\_\_ If quit, when? \_\_\_\_\_

Married  Single  Divorced  Widowed

With whom do you live? \_\_\_\_\_

Occupation? \_\_\_\_\_

**FAMILY HISTORY:** Please list any illnesses in your family, including all cancers (e.g., breast cancer, colon cancer, ovarian cancer, etc.) and blood disorders (e.g., anemia, blood clotting disorders, etc.).

Relationship	Illness, cancer or blood disorder	Age of diagnosis	Are they deceased?
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# DR. WODAJO NEW PATIENT FORM

**ADDITIONAL NOTES:** Please use this space to complete any additional notes that were not completed above. Please mark what section they correspond to.

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## ADVANCE DIRECTIVE

Do you have an Advance Directive, also known as a Living Will?  Y  N

**If yes**, please provide us with a copy for your medical record when you are next in our offices.

**If no**, please consider completing an Advance Directive, as recommended for all adults regardless of health status.

If you were ever unable to speak for yourself, who would the doctors speak to on your behalf?

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Patient Printed Name:** \_\_\_\_\_

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





## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION IN THE FORM OF PHOTOGRAPH, VIDEOTAPE, AUDIOTAPE, OR OTHER MEDIA

The undersigned hereby authorizes Virginia Cancer Specialists and Felasfa Wodajo, MD to record me using photography, videotape, audiotape, and/or other media. This recording is for the purpose of clinical documentation and research. All attempts will be made to conceal any identifying features, such as my face, but I understand that it cannot be guaranteed.

The foregoing is subject to such limitations as indicated below:

I understand that I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to Virginia Cancer Specialists. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. Virginia Cancer Specialists is not responsible for any redisclosure of the information provided.

Signature of Patient (or Legal Representative\*) \_\_\_\_\_

Patient Printed First Name \_\_\_\_\_ Last Name: \_\_\_\_\_

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

\*Relationship/Authority of Legal Representative: \_\_\_\_\_



**PERMISSION FOR VERBAL COMMUNICATIONS**

To protect the patient's privacy and to ensure that our clinic staff and physicians know whom they have permission to communicate with regarding the patient's protected health information, it is helpful for patients to have a Permission for Verbal Communications form on file at Virginia Cancer Specialists.

**Patient's Name**

I permit Virginia Cancer Specialists to discuss health information with the following individuals involved in my medical care or payment of my care:

List individuals and state the person's relationship to the patient.

Name	Phone Number	Relationship
1. _____		
2. _____		
3. _____		

\*\*\*\*\*

This authorization is limited to discussions regarding the following medical condition(s):

If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.

\*\*\*\*\*

This authorization is limited to the following timeframe from

\_\_\_\_\_ (date) to \_\_\_\_\_ (date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

**Patient's Signature**

**Date**

If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

**Name of Personal Representative**

**Relationship to Patient**

**Witness**

**Date**

## PATIENT CONSENT FORM - 3rd PARTY API

A new option for you to view your health information

### What is a 3rd Party API?

An application you can access using a computer, phone or tablet to view the health information in your chart. Depending on the type of app, you will be able to view information such as diagnoses, lab results and medication lists. Apps may offer different features, so you can pick what best meets your needs.

### Why?

New Medicare requirement to give patients the option to view their information using a 3rd Party Application. This is in addition to our patient portal, My Care Plus.

### How?

- Complete consent for 3<sup>rd</sup> party API.
- Request a registration access code from our office. (\*\*Codes expire after 7 days.)
- Access the iKnowMed API Portal website to enter your code and create an account. <https://apiaccess.mckesson.com>
- You will need to use Chrome to access the iKnowMed API Portal.
- Applications that meet the iKnowMed security and technical requirements will be listed.
- You may select any applications from the list, and depending on the application, access them from a computer, phone or tablet.

*Registration is open for patients as of 9/3/18, as 3rd party applications become available they will be added the website.*

By signing below, I hereby consent to use of the 3<sup>rd</sup> party API technology. At any point in time, it is my right to decline the use of 3<sup>rd</sup> party API.

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Patient's DOB

\_\_\_\_\_  
IKM ID

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Practice Staff  
[Confirming user's identity and authority]

\_\_\_\_\_  
Date

Staff: Complete consent process in IKM then scan document.