NEW PATIENT FORM SANDEEP J KHANDHAR, MD

Last Name **First Name** **M.I.**

Today's date: _____ **DOB** _____

Reason for Visit: _____

_____

Referring Physician: **Phone Number:** _____

First Name: _____ **Last Name:** _____

Primary Care Physician: **Phone Number:** _____

First Name: _____ **Last Name:** _____

Pulmonologist: **Phone Number:** _____

First Name: _____ **Last Name:** _____

Oncologist: **Phone Number:** _____

First Name: _____ **Last Name:** _____

Email: _____

MEDICAL HISTORY

Do you have a history of (please check all that apply):

- ☐ Atrial Fibrillation
  If checked, Do you take blood thinners? If yes, explain:

  _____

  _____
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clot?
- ☐ Cancer
- ☐ Diabetes
- ☐ DVT
- ☐ Emphysema/COPD
- ☐ Heart Disease or Heart Attack (MI)
- ☐ Heart Valve Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Interstitial Lung Disease
- ☐ Pulmonary Fibrosis
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Disease
- ☐ Myasthenia Gravis
- ☐ Pneumothorax/Collapsed lung?
- ☐ Pulmonary embolus (PE)
- ☐ Pulmonary Hypertension
- ☐ Psychiatric disorder
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid problems
- ☐ TIA
- ☐ Psychiatric disorder
- ☐ Use Home Oxygen
- ☐ Vascular Disease (problem with arteries)?
  If yes, explain:

  _____

  _____

Other Medical Conditions:

_____

_____

_____

_____

_____

PREVIOUS SURGERIES

PREVIOUS HOSPITALIZATIONS

ALLERGIES

Do you have any drug Allergies? ☐ Y ☐ N If yes, please list your allergies & describe your reaction

Latex Allergy? ☐ Y ☐ N Allergy to Iodine? ☐ Y ☐ N If yes, IV (contrast dye)? ☐ Y ☐ N Topical Iodine? ☐ Y ☐ N

CURRENT MEDICATIONS (PLEASE BRING LIST OF MEDICATIONS THAT ARE NOT LISTED HERE)

Medication	Dose	How many times per day?	Reason for taking

SOCIAL HISTORY AND PREVENTATIVE HEALTH MAINTENANCE

Ethnicity (circle or leave blank)- Hispanic/Latino or Non Hispanic/Latino

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Occupation: _____

If Retired, What did you do before you retired? _____

With whom do you live? _____

What are your hobbies - what do you do for fun? _____

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 vape: ☐ Y ☐ N Do you exercise regularly: ☐ Y ☐ N

If yes, what type of exercise, and how often: _____

Do you use recreational drugs? ☐ Y ☐ N How often? _____ How much? _____

What type? _____ If quit, when? _____

Last bone density scan: _____ Last colonoscopy: _____

Last pneumonia vaccine: _____ Last mammogram: _____

Have you had a flu vaccine this flu season (Sep-March)? ☐ Y ☐ N

FAMILY HISTORY

Have any of your relatives ever had lung cancer? ☐ Y ☐ N Who? _____ at what age? _____

Any other cancer? ☐ Y ☐ N Who? _____ What Kind of Cancer? _____

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

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

NEW PATIENT FORM SANDEEP J KHANDHAR, MD

SYMPTOMS: Please list any symptoms you may have in the categories below. Mark all that apply.

Constitutional

- ☐ Poor Energy Level
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Loss (Unintentional over last 3 months?)

f yes, explain: _____

_____

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
- ☐ Sputum (Bloody?)

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
- ☐ Prostate Problems
- ☐ Difficulty Urinating after surgery
- ☐ Required Catheterization after surgery?

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
- ☐ High Blood Sugar
- ☐ Thyroid Problems

Hematological

- ☐ Nose Bleeds
- ☐ Bleeding Gums
- ☐ Purple Spots on Hands
- ☐ Bruising
- ☐ History of Blood Transfusion

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: _____

_____

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: _____

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 #: _____

1. 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).
2. 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.
3. 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.
4. 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 _____
FOR OFFICE USE ONLY

EMPLOYEE INITIALS _____

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: _____

Virginia Cancer Specialists Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained and employee signature:

_____

_____

_____

Virginia Cancer Specialists

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**

Virginia Cancer Specialists

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 3rd 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 3rd party API technology. At any point in time, it is my right to decline the use of 3rd party API.

_____ _____ _____

Patient's Name (PRINT) Patient's DOB IKM ID

_____ _____

Patient's Signature Date

_____ _____

Signature of Practice Staff Date

[Confirming user's identity and authority]

Staff: Complete consent process in IKM then scan document.