

At Virginia Cancer Specialists, our main focus is creating a personalized care plan just for you. We take the time to understand what makes you unique and why you've come to us. When you arrive, we'll ask questions to tailor your care, and we'll check in periodically to ensure we're meeting your needs.

Northern Virginia stands out because it's incredibly diverse, with 68.1% of its residents being first-generation immigrants. We're here to respect and cater to your cultural differences based on your ethnic background and your preferred language. We value your sexual orientation, gender identity, and pronouns to communicate with you respectfully.

When you visit us, we'll assess your mental health and consider your social, spiritual, and financial concerns to create a comprehensive treatment plan. We'll work with other healthcare providers, your insurance company, and our staff to address any specific needs you have.

Our commitment extends beyond your care. We use this information to build a Health Equity Plan, ensuring that everyone, regardless of their background, has equal access to our supportive care. We embrace the diversity of our employees, physicians, and patients, and we partner with community organizations to meet your social needs. We are committed to helping those in need.

**Thank you for joining us in this effort!**

**The Providers and Staff at Virginia Cancer Specialists**

# NEW PATIENT FORM

SANDEEP J. KHANDHAR, MD

CHRISTOPHER R. JOHNSON, MD

\_\_\_\_\_  
Last Name First Name M.I.

Today's date: \_\_\_\_\_ DOB \_\_\_\_\_

Reason for Visit: \_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

Referring Physician: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Primary Care Physician: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Pulmonologist: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Telephone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

## 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:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# NEW PATIENT FORM

## SOCIAL HISTORY AND PREVENTATIVE HEALTH MAINTENANCE

Preferred Language (written or spoken): \_\_\_\_\_ Race: \_\_\_\_\_

Ethnic Background: \_\_\_\_\_ Are you of Ashkenazi Decent?:  Y  N

Marital Status: Married  Single  Divorced  Widowed

Currently Employed?  Y  N If yes, occupation: \_\_\_\_\_

If Retired, What did you do before you retired? \_\_\_\_\_

With whom do you live/support system? \_\_\_\_\_

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?:  Y  N Have you had your COVID19 vaccination?  Y  N

Have you received any COVID boosters? If so, how many \_\_\_\_\_

Gender (Assigned at birth):  Male  Female

Preferred pronouns:  He/Him/His  She/Her/Hers  They/Them/Theirs  Unspecified  Other (please describe)

Gender Identity:  Male  Female  Female to Male (FTM)/Transgender  Male to Female (MTF)/Transgender

Nonbinary  Other (please specify)  Choose not to disclose

Sexual Orientation:  Straight/Heterosexual  Gay/Lesbian  Bisexual  Choose not to disclose

Other (please describe)

## 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? \_\_\_\_\_

# NEW PATIENT FORM

**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?)

If 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: \_\_\_\_\_  
\_\_\_\_\_

# NEW PATIENT FORM

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

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

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

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

## 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: \_\_\_\_\_

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

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

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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 #: \_\_\_\_\_

- 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:

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**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**