



NEW PATIENT INTAKE - ADULT FORM

Welcome to Denver Cyberknife (DBA Anova Cancer Care). This questionnaire is intended to be a COMPLETE account of your medical history. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

Chart: _____ **Date** _____

Name: _____ **Nickname:** _____ **D.O.B:** _____ **Age:** _____

Address (Street, City, State, Zip) _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Social Security#: _____ **Marital Status:** _____ **Email:** _____

Emergency Contact: _____ **Relation to Patient:** _____

Home: _____ **Cell:** _____ **Work:** _____

Referring Dr. _____ **Primary Care Dr.** _____

Required Fields: Not Reporting **Ethnicity:** Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____ **Race:** _____

PHARMACY Name, Address, Phone _____

PERSONAL/PAST MEDICAL HISTORY Height: _____ ft _____ in Weight: _____ lbs

Can you have an MRI scan? Yes No What cancer(s) have you been diagnosed with? _____

Hospitalized in the last 10 yrs? Yes No Previous Chemotherapy? Radiation therapy? _____

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure Disorder | FEMALE PT's ONLY: | MALE PT's ONLY: |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Uterine Prolapse | <input type="checkbox"/> Erectile Dysfunction |
| <input type="checkbox"/> Bladder Prolapse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Vaginal Prolapse | <input type="checkbox"/> Penile Discharge |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Total Hysterectomy | <input type="checkbox"/> Testicular Pain |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Partial Hysterectomy | <input type="checkbox"/> Testicular Mass |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Abnormal Periods | <input type="checkbox"/> Spermatocele |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Stone | | | <input type="checkbox"/> Hydrocele |
| <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Liver Disease | Other Medical Problems: | | <input type="checkbox"/> Hypogonadism |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neuropathy | _____ | | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | _____ | | |

PAST SURGICAL HISTORY

- | | | | |
|---------------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Intestine | <input type="checkbox"/> Fallopian Tubes | <input type="checkbox"/> Other Surgeries: _____ |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach | <input type="checkbox"/> Ovaries | |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Appendix | <input type="checkbox"/> Prostate | Do you have any replacement Joints? <input type="checkbox"/> No <input type="checkbox"/> Yes: |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Testes | <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <i>Heart</i> <input type="checkbox"/> valves <input type="checkbox"/> stents |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Kidney | <input type="checkbox"/> Penis | Please give details of past surgeries checked |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Bladder | <input type="checkbox"/> Vasectomy | _____ |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Uterus | <input type="checkbox"/> Back | _____ |

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PATIENT: _____

CURRENT MEDICATIONS ___ None
 (Please list your dose with each medication)

ALLERGIES ___ No known medication allergies
 (Please list the associated symptoms)

SOCIAL HISTORY

Alcohol Use? No Yes- How much? _____ Recreational Drugs? No Yes- How much? _____

Tobacco Use? ___ Never Smoked ___ Smoker: _____ packs per day ___ Former Smoker: quit _____ years ago

FAMILY HISTORY (please indicate family member diagnosed with the following)

M – mother, F - father, S – sister, B - brother, MG – maternal grandparent, PG – paternal grandparent

- | | | | |
|--------------------|-----------------------|-------------------|--------------------|
| ___ Bladder Cancer | ___ Prostate Cancer | ___ Diabetes | ___ Obesity |
| ___ Brain Cancer | ___ Testicular Cancer | ___ Heart Disease | ___ Blood Disorder |
| ___ Breast Cancer | ___ Other Cancers | ___ Hypertension | ___ Other _____ |
| ___ Kidney Cancer | _____ | ___ Stroke | _____ |
| ___ Lung Cancer | _____ | | |

REVIEW OF SYSTEMS No symptoms at this time _____

- | | | | |
|---------------------------|---------------------------|----------------------------|--------------------------|
| ___ Sleep Pattern | ___ Vision Change/Loss | ___ High blood pressure | ___ Weakness |
| ___ Appetite | ___ Ear Pain | ___ Abdominal Pain | ___ Balance |
| ___ Bowels | ___ Ear Ringing | ___ Abdominal Pain | ___ Confusion |
| ___ Energy Level | ___ Hearing Loss | ___ Vomiting | ___ Numbness or Tingling |
| ___ Physical Activity | ___ Facial Pain | ___ Diarrhea | ___ Speech problems |
| ___ Rashes | ___ Nosebleeds | ___ Ongoing Constipation | ___ Falling |
| ___ Abnormal Lumps | ___ Difficulty Swallowing | ___ GERD / Indigestion | ___ Dizziness |
| ___ Abnormal Skin Color | ___ Difficulty Breathing | ___ Blood in Urine | ___ Anxiety |
| ___ Brain Injuries | ___ Coughing | ___ Painful Urination | ___ Depression |
| ___ Head Trauma | ___ Wheezing | ___ Excessive Urination | ___ Claustrophobia |
| ___ Loss of Consciousness | ___ Shortness of Breath | ___ Urinary Urgency | ___ Diabetes |
| ___ Headaches | ___ Chest Pains | ___ Urination at night | ___ Thyroid Problems |
| ___ Double Vision | ___ Abnormal Heart Beats | ___ Muscle Pain | ___ Blood Clots |
| ___ Eye Discharge | ___ Swelling of limbs | ___ Muscle Weakness | ___ Easy Bruising |
| ___ Eye Pain or Itching | ___ Discomfort breathing | ___ Swollen or Sore joints | ___ Enlarged Lymph Nodes |
| ___ Flashes of Light | ___ Stents | ___ Arthritis | ___ Pain (explain) |
| ___ Sensitive to Light | ___ Pacemaker | ___ Neuropathy / Pain | _____ |

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PATIENT: _____

HIPAA NOTICE ACKNOWLEDGEMENT

The Practice of Denver Cyberknife (DBA Anova Cancer Care) is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examinations and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclose your PHI for the purposes of treatment, payment and health care operations without your written authorization.

We will use your PHI during the course of your treatment if the physician determines we will need to consult with a specialist in another area. He will share the information with the specialist and obtain his/her input. We will also use your PHI to contact you by phone, if we need to speak to you about a medical condition, or to remind you of medical appointments. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

You have the right to receive the Notice of Privacy Practices for Protected Health Information from our office or visit our website at www.anovacancercare.com. I acknowledge that I have been given the option to receive a copy of the Notice of Privacy Practices for the practice of Denver Cyberknife (DBA Anova Cancer Care).

FINANCIAL SERVICE AGREEMENT

BILLING PRACTICES: Our policy is to bill the patient's insurance company for service rendered. However, Insurance coverage is another form of payment but ultimately it is your responsibility to pay for all services rendered. If you do not have insurance, payment is due at the time services are rendered. We will collect any known or estimated co-payments, co-insurance or deductibles at the time of service. Additionally, the responsible party will be billed for services rendered in full, should the insurance company deny coverage due to non-covered benefits, lack of referral, lack of proper reporting of incident/accident or lack of individual coverage, where applicable. ***Please Note: Professional services provided by Gregg Dickerson, M.D. are billed through Urology Associates, P.C.**

COLLECTION ACTIVITY: Any account balance(s) that are not paid within ninety (90) days from the date of service may be forwarded to a collection agency. If deemed necessary, Denver Cyberknife (DBA Anova Cancer Care) reserves the right to forward the account balance(s) to a collection agency prior to ninety (90) days from the date of service. Any and all phone numbers provided to our office be it residential, employment or wireless, are authorized methods of communication by our office or by a collection agency in regards to any outstanding collection balances. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, interest and court costs.

PAYMENT FOR SERVICES: For payment of your financial obligation we accept Cash, Check, Visa, MasterCard or Discover.

If you have any questions or concerns, please speak with the billing dept. at (303)733-0662. **Please note: It is the patient's responsibility to understand their individual insurance benefits.**

I hereby assign to Denver Cyberknife (DBA Anova Cancer Care) all benefits for medical expenses. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I authorize the provider named above to release my medical records and all medical information requested by my insurance company.

Patient/Legal Guardian Signature

Date

Relation to Patient

CONSENT TO CONTACT/LEAVE INFORMATION

I authorize the staff of Anova Cancer Care to speak with or leave a message regarding my results with the following individuals:

_____ Name	_____ Relation to Patient	_____ Phone Number	_____ Speak with	_____ Message/VM
_____ Name	_____ Relation to Patient	_____ Phone Number	_____ Speak with	_____ Message/VM
_____ Name	_____ Relation to Patient	_____ Phone Number	_____ Speak with	_____ Message/VM

Patient/Legal Guardian Signature

Date

Relation to Patient

Pain Worksheet

Name: _____

Date: __/__/__

Where is your pain now?

Mark areas on diagram where you feel the sensation and use appropriate symbols to describe the type of sensation you are experiencing.

Ache ^^^^

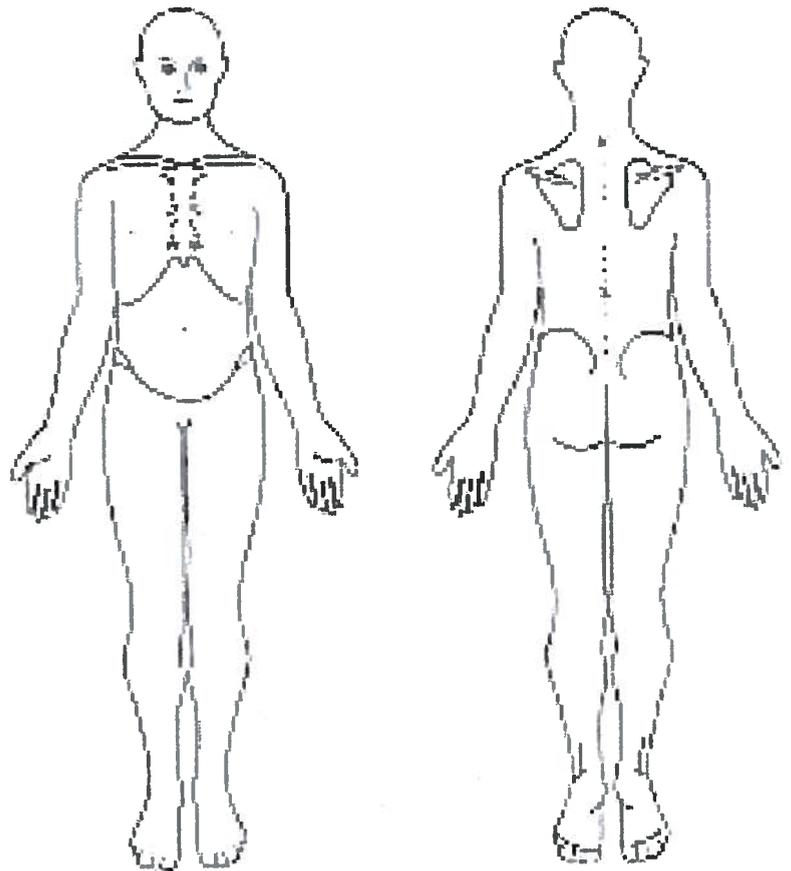
Numbness 0000

Pins & Needles +++++

Burning xxxxx

Radiating Pain /////

Sharp Pain =====



How bad is your pain now? Circle the number corresponding to your pain level

No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Worst Pain