Tennessee Valley

TVGO

Gynecologic Oncology

WELCOME:

Enclosed you will find our Patient Registration Form, a Patient History Form, a Health Information access Form, an Authorization for Disclosure Form, a copy of our Privacy Notice and a Financial Policy.

We ask that you complete our comprehensive medical forms at your first visit. This information provides critical facts about you as well as a detailed cancer history of your family. All of this information is taken into consideration as we plan a course of action for you.

Be prepared to provide a picture ID, any appropriate insurance cards, and a list of all current medications. If you do not have insurance, you will be required to pay $50 at your first visit. There will be a $25 fee for all cancellations without a 24 hour notice.

We hope this information is helpful as you begin your journey with our practice. Whether you are a new patient or returning for follow-up care, we've found our office staff can best meet your needs if you understand how our office functions. Your unique needs are best met by understanding the active role you will take in your care.

Please help us individualize your care by filling out our return visit form at all follow-up appointments. This form helps us to identify areas of your health that need to be addressed.

TELEPHONE CALLS TO THE NURSE:
When calling the office to speak with the nurse, you may be asked to leave a message as our nurses are in clinic Monday through Thursday 8 a.m. to 5 p.m. Messages are checked throughout the day. Medical questions and concerns will be addressed in a timely manner. Calls made after hours will be answered by the answering service and the physician on call will return emergency calls in a timely manner.

PRESCRIPTIONS: (Please note we have a 48-hour refill prescription policy)
When calling the office for a refill on your medication, your call may be routed to a prescription hotline. You will be asked to leave your name, date of birth, call back number, name and dose of Rx, and the name and number of your pharmacy. It may take up to 48 hours for your refill to be approved by your physician and called in to your pharmacy. For safety reasons, our office does not refill medications prescribed by other physicians. We do not refill narcotic prescriptions after office hours.

DIAGNOSTIC TESTS AND PROCEDURES:
Routine tests (such as mammograms) should be ordered by your primary care physician. For tests ordered by TVGO (i.e. diagnostics, biopsies, pap smears, etc.), you will receive your results within TEN (10) working days. If you have not received your results after FIFTEEN (15) working days, please call for your results.

TENNESSEE VALLEY
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GYNECOLOGIC ONCOLOGY

LAST NAME: _____ FIRST NAME: _____ MI _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____AGE_____ SOCIAL SECURITY #: _____

MALE: ____ FEMALE: ____ SINGLE: ____ MARRIED: ____ DIVORCED: ____ WIDOW: _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

E-MAIL ADDRESS: _____

EMPLOYER NAME: _____ OCCUPATION: _____

EMPLOYER ADDRESS:_____CITY:_____STATE:_____ZIP:_____

PHARMACY NAME: _____ TELEPHONE #: _____

Name of your Physician/Primary Care Provider: _____

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

ID#: _____ GROUP#:_____ CO-PAY: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

DOB: _____ SOCIAL SECURITY #: _____ TELEPHONE #: _____

SECONDARY

INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:_____

ID#: _____ GROUP#:_____ CO-PAY: _____

POLICY HOLDER: _____ RELATIONSHIP: _____

DOB: _____ SOCIAL SECURITY #: _____ TELEPHONE #: _____

Payment is expected at the time of the visit, unless other arrangements are made in advance. You are responsible for all deductibles, co-insurance, and any fees not covered under your insurance policy. Thank you.

SIGNATURE: _____ DATE: _____

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WHY DID YOU COME TO SEE THE DOCTOR TODAY?_____
_____

PAST MEDICAL HISTORY
HAVE YOU EVER HAD OR CURRENTLY BEING TREATED FOR? (PLEASE CHECK ALL THAT APPLY)

___ ALCOHOLISM/SUBSTANCE ABUSE
___ KIDNEY DISEASE
___ ALLERGIES
___ BREAST DISEASE
___ BLOOD CLOTS
___ CANCER: TYPE_____
___ BLEEDING PROBLEMS
___ DIABETES
___ EPILEPSY/SEIZURES
___ OTHER: _____
___ LUNG DISEASE: TYPE:_____
___ HIGH BLOOD PRESSURE
___ PHLEBITIS
___ HEART DISEASE
___ TUBERCULOSIS
___ HIGH CHOLESTEROL
___ LIVER DISEASE
___ THYROID DYSFUNCTION

HAVE YOU EVER BEEN HOSPITALIZED? □YES □NO
IF YES, WHEN, WHERE AND FOR WHAT? _____
HAVE YOU EVER HAD SURGERY? □YES □NO
IF YES, WHEN, WHERE AND FOR WHAT? _____
ARE YOU ALLERGIC TO ANY MEDICATIONS? □YES □NO
PLEASE LIST AND EXPLAIN REACTION: _____
_____

DO YOU HAVE AN ALLERGIE TO LATEX: □YES □NO

OTHER ALLERGIES:
_____

DO YOU HAVE MENSTRUAL PERIODS? □ YES □ NO DATE OF LMP: _____

ARE YOUR MENSTRUAL PERIODS: □ REGULAR □ MODERATE □ HEAVY □ IRREGULAR

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____HOW MANY CHILDREN DO YOU HAVE?_____

HAVE YOU BEEN SEXUALLY ACTIVE IN THE PAST? □YES □NO
ARE YOU CURRENTLY SEXUALLY ACTIVE? □YES □NO

IF YOU ARE SEXUALLY ACTIVE, WHAT FORM OF BIRTH CONTROL ARE YOU USING?

□ NOTHING
□ WITHDRAWAL
□ CONDOMS
□ SPONGE
□ FOAM
□ DIAPHRAGM
□ IUD
□ RHYTHM METHOD
□ BIRTH CONTROL PILLS
□ TUBAL LIGATION
□ PARTNER VASECTOMY
□ OTHER:_____

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Does your <u>family</u> have a history of (please check all that apply to your family)

□ Diabetes	□ Epilepsy/Seizures	□ Breast Disease
□ Heart disease	□ Phlebitis	□ Lung Disease
□ Kidney Disease	□ Allergies	□ Bleeding Problems
□ Liver Disease	□ Hypertension	□ Other
□ Tuberculosis	□ Blood Clots	□
□ Thyroid Dysfunction	□ Cancer	□

Do you use: _____Tobacco (how much):_____Alcohol _____

Have you been tested for HIV? □ Yes □ No
Date and Results:_____

REVIEW OF SYSTEMS (please check all that apply to you)

Skin	□ Normal	□ Rash	□ Ulcers
Neurological	□ Normal	□ Seizures	□ Neuropathy
			□ Syncope/Pass Out
Psychiatric	□ Normal	□ Depression	□ Thyroid Disease
Endocrine	□ Normal	□ Diabetes	□ Hot Flashes
Urinary	□ Normal	□ Blood in Urine	□ Pain in Urination
		□ Leakage of Urine	□ Urgency to Void
Genital	□ Normal	□ Abnormal Bleeding	□ Vaginal Discharge
		□ Breast Pain	
Sex Function	□ Normal	□ Painful Intercourse	□ Bleeding after intercourse
Hematology	□ Normal	□ Easy Bruising	□ Spontaneous Bleeding
		□ Lack of Desire	□ Enlarged Lymph Nodes
Allergy	□ Normal	□ Seasonal Allergies	□ Drug Allergies
General	□ Normal	□ Weight Loss	□ Fatigue
Eyes	□ Normal	□ Change in Vision	□ Sore Throat
Ears / Mouth	□ Normal	□ Problems Hearing	□ Ulcers
Cardiovascular	□ Normal	□ Chest Pain	□ Shortness of Breath with exercise
		□ Shortness of Breath in Bed	
Respiratory	□ Normal	□ Shortness of Breath	□ Wheezing
		□ Respiratory Infection	□ Cold
Gastrointestinal	□ Normal	□ Nausea/Vomiting	□ Diarrhea
Musculoskeletal	□ Normal	□ Muscle Weakness	□ Arthritis
		□ Blood in Stool	

HealthCare Screenings Tests: (please list date and place of test)

PAP TEST: _____ MAMMOGRAM: _____
BONE DENSITY: _____COLORECTAL SCREEN: _____

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PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT PHONE NUMBER: _____

REQUEST TO RELEASE HEALTH INFORMATION ACCESS

I HEREBY RELEASE TENNESSEE VALLEY GYNECOLOGIC ONCOLOGY TO COMMUNICATE TO THE FOLLOWING FAMILY MEMBERS OR FRIENDS.

NAME	RELATIONSHIP	PHONE NUMBER

_____ _____
PATIENT SIGNATURE DATE AND TIME

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE PT. RELATIONSHIP

_____ _____
WITNESS SIGNATURE TODAY'S DATE

TENNESSEE VALLEY
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PATIENT NAME: _____

DATE OF BIRTH: _____

PLEASE PLACE A CHECK MARK ☑ IN THE BOXES BELOW FOR YOURSELF AND FOR EACH FAMILY MEMBER WHO HAS COLON, ENDOMETRIAL, BREAST OR OVARIAN CANCER.
(age refers to you or your family's age when the cancer was diagnosed)

	COLON CANCER	**COLON CANCER**	**ENDOMETRIAL CANCER**	**ENDOMETRIAL CANCER**	**BREAST CANCER**	**OVARY CANCER**
	Before age 50	After age 50	Before age 50	After age 50	Before age 50	Any age
Yourself						
Mother						
Father						
Sister (s)						
Brother (s)						
Daughter (s)						
Son (s)						
Mother's Side						
Grandmother						
Grandfather						
Aunt (s)						
Uncle (s)						
Cousin (s)						
Father's Side						
Grandmother						
Grandfather						
Aunt (s)						
Uncle (s)						
Cousin (s)						

ARE YOU OF ASHKENAZI JEWISH DESCENT: □YES □NO

DO YOU HAVE MALE RELATIVES WITH BREAST CANCER? □YES □NO

CONSIDER FURTHER EVALUATION FOR A HERADITARY CANCER SYNDROME IF:

- o COLON OR ENDOMETRIAL CANCER DIAGNOSED BEFORE AGE 50
- o TWO FIRST DEGREE RELATIVES WITH COLON OR ENDOMETRIAL CANCER AT ANY AGE
- o TWO OR MORE RELATIVE WITH BREAST CANCER BEFORE AGE 50
- o ASHKENAZI JEWISH DESCENT AND ANY CASES OF BREAST CANCER BEFORE AGE 50 OR OVARIAN CANCER AT ANY AGE
- o ANY MALE RELATIVE WITH BREAST CANCER