CLERMONT ONCOLOGY CENTER

GOPAL KUNTA, M.D
Board Certified Medical Oncologist
2737 Citrus Tower Blvd Clermont, FL 34711
P: (352)242-1366 F: (352)242-1372

Patient Medical History Form

Patient Name: ______________________________ Date: ____/____/____

Date of Birth: ___/___/___ Age: ______ ☐ Male ☐ Female

Address: ______________________ City: ___________ State: _____ Zip: ______

Home Phone: (_____) ______________ Cell Phone: (_____) ______________

May we leave a message on your answering machine or voicemail? ☐ Yes ☐ No

Email Address: ________________________ May we email you? ☐ Yes ☐ No

Preferred Language: ____________________

Ethnicity/Race: ☐ White ☐Hispanic/Latino ☐African American ☐Native American ☐ Asian ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other (Specify) __________

Emergency Contact Name: ______________________________

Relationship: ____________________ Phone: (_____) ______________

Primary Care Physician: ____________________ Phone: (_____) ______________

Referring Physician (if different) ______________ Phone: (_____) ______________

Please list any additional Physicians you see:

________________________________ Phone: (_____) ______________

________________________________ Phone: (_____) ______________

________________________________ Phone: (_____) ______________

Employment Status:

☐ Employed/Self Employed ☐ Unemployed ☐ Retired ☐ Disabled

Name of Employer: ____________________ Phone: (_____) ______________

Advance Directives:

Living Will ☐ Yes ☐ No ☐ Unknown

Power of Attorney ☐ Yes ☐ No ☐ Unknown Relationship to You: ______________

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Patient Name: ______________________________ Date: ____/____/____

Reason for this Visit: ______________________________

Medical History: Check the items that apply to you (current or history)

☐ None	☐ Glaucoma/Cataracts	☐ Cirrhosis of Liver
☐ Chronic Lung (COPD)	☐ Lymphoma	☐ Hepatitis A/B/C
☐ Pneumonia/Bronchitis	☐ Problems with Anesthesia	☐ Pancreatitis
☐ TB (Tuberculosis)	☐ High Blood Pressure	☐ Kidney Stones
☐ Sleep Apnea	☐ Congestive Heart Failure	☐ Kidney Disease/Failure
☐ Colon Polyps	☐ Rheumatic Fever	☐ Enlarged Prostate
☐ Crohn's Disease	☐ Irregular Heartbeat	☐ Asthma
☐ Irritable Bowel Syndrome	☐ Blood Clots	☐ Lupus-Autoimmune
☐ Ulcerative Colitis	☐ Drug Use	☐ Hearing Loss
☐ Stomach Ulcers	☐ Hiatal Hernia	☐ Leukemia
☐ Gerd/Heartburn	☐ Gallstones	☐ Diabetes
☐ Freq. Urinary Tract Infection	☐ Peripheral Vascular Disease	☐ High Cholesterol
☐ Heart Attack	☐ Heartburn/Reflux	☐ Frequent Infections
☐ Anemia	☐ Depression	☐ Reynaud's Syndrome
☐ Osteoarthritis	☐ Chronic Back Pain	☐ Osteoporosis
☐ Fracture	☐ Stoke	☐ Neuropathy
☐ Parkinson's Disease	☐ Paralysis	☐ Seizure
☐ Migraines	☐ Shingles	☐ Cancer
☐ Anxiety	☐ Thyroid Disease	☐ Atrial Fibrillation
☐ Heart Disease	☐ Heart Murmur	☐ Blood Disorder
☐ Bleeding Disorder		

Details of Medical History: ______________________________

Cancer History: ______________________ Type: ______________________

Date Diagnosed: ______________ Physician: ______________________

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Patient Name: ______________________________ Date: ____/____/____

Past Surgical History: (Please circle and date any surgeries and/or procedures that you have undergone)

Coronary Bypass	Date: ________	Knee Replacement	Date: ________
Angioplasty	Date: ________	Rotator Cuff Repair	Date: ________
Pacemaker	Date: ________	Cataract	Date: ________
Cardiac Valve Surgery	Date: ________	Gallbladder	Date: ________
Hemorrhoidectomy	Date: ________	Hysterectomy	Date: ________
Prostate Operation	Date: ________	Prostatectomy	Date: ________
Hernia Repair	Date: ________	Appendectomy	Date: ________
Tonsillectomy	Date: ________	Hip Replacement	Date: ________
Mastectomy	Date: ________	Lumpectomy	Date: ________

Other Operations: ______________________________

Social History:

Tobacco Use: (Present and/or past)

❑ Chewing Tobacco ❑ Never Smoked

❑ Quit Smoking When: ________ How many years did you smoke: ______ How many packs: _____/day

❑ Currently Smoke ❑ Cigarettes ❑ Pipe ❑ Cigars How many years: _____ How many packs: ____/day

Alcohol History: (Present and/or past)

❑ Non Drinker

❑ Beer Number of bottles ________ per ❑ Day ❑Week ❑Month

❑ Wine Number of glasses ________ per ❑ Day ❑ Week ❑ Month

❑ Liquor Number of glasses ________ per ❑ Day ❑ Week ❑ Month

Health Maintenance:

Sigmoidoscopy/Colonoscopy: ❑ Yes ❑ No Date: ______________________

Last Mammogram: Date & Location ______________________________

Last Bone Density: Date & Location ______________________________

Last EGD: Date & Location ______________________________

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Patient Name: ______________________ **Date:** ____/____/____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:
- ☐ Weight Loss
- How much ____________
- Over what time period ________
- ☐ Fevers
- ☐ Max Temp ____________
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue

Eyes:
- ☐ Wear Glasses/Contact Lenses
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dry Eyes

Ears, Nose, Throat:
- ☐ Hard of Hearing/Deaf
- ☐ Ringing In Ears
- ☐ Enlarged Lymph Nodes
- ☐ Sore Throat
- ☐ Mouth Pain/Sores

Changes/Difficulty In:
- ☐ Taste
- ☐ Smell
- ☐ Voice

Cardiovascular:
- ☐ Chest Pain/Angina Pectoris
- ☐ Palpitations/Heart Murmur
- ☐ Irregular Heartbeat

Respiratory:
- ☐ Chronic/Frequent cough
- ☐ Bloody Sputum
- ☐ Shortness of Breath

Gastrointestinal:
- ☐ Difficult or Painful Swallowing
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Lump or Sensation in Throat
- ☐ Food Sticking
- ☐ Bloating
- ☐ Belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Black or Tarry Stools
- ☐ Hidden Blood in Stool
- ☐ Excessive Rectal Gas/Flatus
- ☐ Poor Appetite
- ☐ Jaundice

- ☐ Kidney Stones
- ☐ Pelvic Pain
- ☐ Incontinence
- ☐ Burning or Pain on Urination
- ☐ Blood in Urine
- ☐ Difficult Urination
- ☐ Men: Prostate Cancer

Musculoskeletal:
- ☐ Joint Pain/Arthritis
- ☐ Muscle or Joint Weakness
- ☐ Back Pain
- ☐ Bone Pain
- ☐ Muscle Pain

Gynecology:
- ☐ Last Period: ________
- ☐ Abnormal Bleeding
- ☐ Vaginal Discharge

Psychiatric:
- ☐ Anxiety/Agitation
- ☐ Depression
- ☐ Crying for no reason
- ☐ Insomnia
- ☐ Alcohol/Drug

Hematologic:
- ☐ Easy Bruising
- ☐ Gum or Nose Bleeding
- ☐ Blood Transfusion

Endocrine:
- ☐ Heat or Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Skin Dryness
- ☐ Excessive Urination
- ☐ Weight Problem
- ☐ Hot Flashes

- ☐ Breast Pain/Lump
- ☐ Breast Discharge
- ☐ Breast Rash

Allergies/Immunology:
- ☐ History of Allergies
- ☐ Chronic Infections

Skin:
- ☐ Rashes/Itching
- ☐ Change in Skin Color
- ☐ Existing/New Moles
- ☐ Varicose Veins
- ☐ Skin

Neurological:
- ☐ Numbness/Tingling
- ☐ Arm/Leg Weakness
- ☐ Headache
- ☐ Light-Headed/Dizzy
- ☐ Tremors

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Patient Name: ______________________________ Date: ____/____/____

Family Medical History: Indicate any family members with cancer, blood disease or disease.

	Age	Disease	If deceased, cause of death
Father:	______	______________	______________________
Mother:	______	______________	______________________
Siblings:	______	______________	______________________
	______	______________	______________________
	______	______________	______________________

Drug Allergies: (List all medication allergies)

Medication: ______________________ Reaction: ______________________

Medication: ______________________ Reaction: ______________________

Medication: ______________________ Reaction: ______________________

Medication: ______________________ Reaction: ______________________

Are you allergic to:

☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye/IV Contrast ☐ Eggs ☐ Peanuts

Other: ______________________ Reaction: ______________________

Other: ______________________ Reaction: ______________________

Pharmacy: ____

Address: ____

Phone Number: (_____) ______________

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Patient name: ______________________________ Date: ____/____/____

Medication List:

Your treatment can be affected by any medication that you take. It is important that your Physician has updated and correct information.

List all medications (including non-prescription) that you are currently taking:

Medication	Dose	Frequency	Ordering Physician

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Patient Name: ______________________ **Date:** ____/____/____

Insurance Information

Primary Insurance Carrier: ______________________

Name of Primary Policy Holder: ______________________

Policy Holder's Date of Birth: ____/____/____

Policy Holder's Employer: ______________________ Phone: (____) ________

Member Id: ______________________ Group Id: ______________________

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: ______________________

Name of Secondary Policy Holder: ______________________

Policy Holder's Date of Birth: ____/____/____

Policy Holder's Employer: ______________________ Phone: (____) ________

Member Id: ______________________ Group Id: ______________________

Does plan have prescription coverage? ☐ Yes ☐ No

Pharmacy Insurance Carrier: ______________________

Name of Pharmacy Policy Holder: ______________________

Id Number: ______________________ Rx Group: ______________________

PCN Number: ______________________ Bin Number: ______________________

I certify that the information provided is accurate. I will notify Clermont Oncology Center, LLC of any changes as soon as they become available. I understand that it is my responsibility to update any changes in insurance or I may be held liable for the full balance of my treatment.

______________________ ______________

Patient Name (Print) Date

____

Patient Or Guarantor (Signature)

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Clermont Oncology Financial Agreement

<u>Commercial Insurance:</u> Clermont Oncology Center will bill insurance **provided** that your carrier will make payment directly to our office. Clermont Oncology Center will attempt to bill your insurance company twice to collect payment. In the event your insurance company does not pay for billed services, the balance will be your responsibility. We will verify the insurance coverage and let you know what, if any, percentage you will be responsible to pay. Payment is due on the date of service.

<u>Medicare:</u> Clermont Oncology Center will accept assignment from Medicare. You are responsible for the 20% co-payment on the date of service. If you have a Medicare supplement, we will file a claim with them provided they will make payment to our office.

<u>Insurance Release:</u> I authorized Clermont Oncology Center to release to my insurance company and to communicate with hospitals and other medical providers and required information regarding services provided including medical, psychiatric, laboratory studies, HIV testing, and other medical data related to my care. I authorize and insurance or payer to make payment directly to Clermont Oncology Center. A photocopy of this authorization shall be considered as effective and valid for the duration of this claim.

<u>Financial Agreement:</u> I understand that my insurance contract is between me and my insurance company. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being turned over to an outside collections agency. If this becomes necessary, I agree to pay all collection fees which include but are not limited to collection agency fees, court fees, attorney fees, and any other fees for the collection of my account balance. Further, I consent Clermont Oncology Center inquires into my credit history in conformity with legitimate business needs and applicable laws, rules, and regulations.

I have read, understand, and agree to the above Patient Financial Agreement. A copy is available upon request.

Signature: ______________________________ Date: ____/____/____

Spouse/Guarantor Signature: ______________________________ Date: ____/____/____

Witness: ______________________________ Date: ____/____/____

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Patient Name: ______________________________ SSN: ____/____/____

Address: ______________________________ Date of Birth____/____/____

City: __________ State: ________ Zip: ________ Phone Number: (_____) ____________

I authorize Clermont Oncology Center, LLC to use or disclose my Protected Health Information as described below.
The following facility may receive disclosure of protected health information about me.

Name: ______________________________ Address: ______________________________

City: __________ State: ________ Zip: ________ Phone Number: (_____) ____________

Name: ______________________________ Address: ______________________________

City: __________ State: ________ Zip: ________ Phone Number: (_____) ____________

The information that should be disclosed is: ______________________________

I understand that the information used or disclosed maybe subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Clermont Oncology Center, LLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization, cannot be reversed and my revocation will not affect those action.

Unless you sign, no information about alcohol substance abuse, HIV/AIDS, or mental health will be disclosed.
Yes, disclose this information: Signature: ______________________________

This form must be fully completed before signing

Signature: ______________________________ Date: ___/___/___ Date of Birth: ___/___/___

Signature of Guardian or Personal Representative: ______________________________

Date: ____/____/____ Description of Authority: ______________________________

Acknowledgment and Receipt of the PATIENT RIGHTS AND RESPONSIBILITIES: __________ Patient's Initial's
Acknowledgment and Receipt of the HIPPA NOTICE of PRIVACY PRACTICES: __________ Patient's Initial's
Acknowledgment and Receipt of the PATIENT ADVOCATE LETTER: __________ Patient's Initial's
Acknowledgment and Receipt of the COC PRACTICE INTRODUCTION: __________ Patient's Initial's

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I, ____ Date of Birth: _____/_____/_____
request a copy of my complete medical record from the office of:

Name of Practitioner: ____

Address of Practitioner: ____

Phone: (______) ________________________ Fax: (______) ________________________

To be sent to:
Clermont Oncology Center, LLC
Dr. Gopal Kunta
2737 Citrus Tower Blvd
Clermont, Fl 34711
Phone: (352) 242-1366
Fax: (352) 242-1366

For the Purpose of Consultation and/or Treatment Information to Include:

- ☐ All Medical History ☐ Radiology Reports ☐ Psychiatric Records
- ☐ Medical Consults ☐ MV Testing, AIDS/ STD info ☐ Operations Reports
- ☐ Pathology Reports ☐ Lab Reports

It is my understanding that by signing this authorization for release of my records, I am giving permission to Clermont Oncology Center to receive/release copies of any medical, psychiatric, AIDS, Aids related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent does not expire unless I inform Clermont Oncology Center in writing.

Print Patient Name: ____ **Date:** _____/_____/_____

Patient's Signature: ____ **Date:** _____/_____/_____