



Place Label Here

**GENERAL CONSENT FOR CARE AND TREATMENT**

---

**TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
 Signature of Patient or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Patient or Personal Representative

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Signature of Witness

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Witness

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

---

### PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  Male  Female SS#: \_\_\_\_\_

Primary Address: \_\_\_\_\_

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

Home Phone:  Preferred (\_\_\_\_\_) \_\_\_\_\_

Cell Phone:  Preferred (\_\_\_\_\_) \_\_\_\_\_

Secondary Address: \_\_\_\_\_

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

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

Email Address: \_\_\_\_\_ May we email you?  Yes  No

Preferred Language: \_\_\_\_\_

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

Race:  Native American or Alaska Native  Asian  Black or African American

Native Hawaiian or Other Pacific Islander  White  Other

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

Pharmacy Phone # and Cross Streets: \_\_\_\_\_

*(Internal Use Only)*

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

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

---

**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician (if different): \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any additional Physicians you see: (Include Phone #):

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

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

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

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

**Emergency Contact Name:**

\_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

**Employment Status:**

Employed/Self Employed     Unemployed     Retired     Disabled

Occupation (or Former Occupation): \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

**Advanced Directives:**

**Living Will**    Yes    No    Unknown

**Durable Power of Attorney**    Yes    No    Unknown

**DNR**    Yes    No    Unknown

**If yes, please bring a copy with you.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Medical History**

Have you EVER had any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Neurological Disorder/Chronic Headaches | <input type="checkbox"/> Arthritis                           |
| <input type="checkbox"/> Psychiatric Disorder/Illness | <input type="checkbox"/> Blood Pressure Disorder/Hypertension    | <input type="checkbox"/> Pulmonary Embolism/DVT/Blood Clots  |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Stroke                                  | <input type="checkbox"/> Cholesterol Disorder/Hyperlipidemia |
| <input type="checkbox"/> Seizures or Epilepsy         | <input type="checkbox"/> COPD                                    | <input type="checkbox"/> Sleep Apnea                         |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Thyroid Disorder                        | <input type="checkbox"/> Eye Disorder (i.e. Glaucoma)        |
| <input type="checkbox"/> Urinary/Kidney Disorder      | <input type="checkbox"/> Heart Attack/Heart Disease/Atrial Fib   | <input type="checkbox"/> Other                               |

Please list any other medical illnesses or problems and provide details for any of the above conditions:

**Surgery History** Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

**Prior Cancer Treatment** Do you currently have cancer?  Yes  No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:

**Allergies**

Are you allergic to any medications or other substances?  Yes  No Please list allergies and reactions:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Medication List**

Medication Name	Dose	Frequency

Do you have additional medications not listed above?  Yes  No If yes, please use the back of this page to list all others.

**Health Maintenance**

Date of last bone density: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Have you ever had an abnormal PAP smear?  Yes  No

Date of last mammogram: \_\_\_\_\_ Was that mammogram normal?  Yes  No

Date of last colonoscopy: \_\_\_\_\_ Was that colonoscopy normal?  Yes  No

**Obstetrics History**

Are you currently pregnant?  Yes  No If yes, anticipated due date: \_\_\_\_\_

Attempting to conceive?  Yes  No # of Pregnancies: \_\_\_\_\_ # of Births: \_\_\_\_\_ # of Miscarriages: \_\_\_\_\_

**Family Medical History**

Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

**Social History**

Do you currently smoke?  Yes  No If no, previously?  Yes  No

Years smoked: \_\_\_\_\_ Packs per day: \_\_\_\_\_ Do you use other tobacco products?  Yes  No

Consume Alcohol?  Yes  No If yes, drinks per week: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Do you suffer from domestic violence?  Yes  No Do you feel safe at home?  Yes  No

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Review of Systems** Please indicate ALL that you have experienced within the last 6-12 months.

**General**

- |                                 |  |   |                                      |
|---------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> Feeling Tired | <input type="checkbox"/> Fever          | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight Loss   | <input type="checkbox"/> Feeling Poorly |                                      |

**Eyes**

- |   |  |                                   |                                     |
|---|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Dry Eyes          | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Eyesight Problems |                                   |                                     |

**Ear/Nose/Throat**

- |   |                                      |  |                                      |
|---|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Earache     | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Hoarseness      |                                      |

**Heart**

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> None         | <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Palpitations                                   | <input type="checkbox"/> Slow Heart Rate |
| <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Fast heart rate | <input type="checkbox"/> Leg pain, discomfort or fatigue during walking |  |

**Lungs/Breathing**

- |  |                                |  |  |
|--|--------------------------------|--|--|
| <input type="checkbox"/> None                            | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing                          | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Trouble breathing with exertion |                                | <input type="checkbox"/> Trouble breathing when lying flat |  |

**Gastrointestinal**

- |                                    |   |                                       |   |
|------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> None      | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea       |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea         | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Blood in stool |

**Skin**

- |                                       |                                     |                                      |   |
|---------------------------------------|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> None         | <input type="checkbox"/> Acne       | <input type="checkbox"/> Itching     | <input type="checkbox"/> Change in mole |
| <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Skin Wound | <input type="checkbox"/> Breast Lump |   |

**Neurological**

- |                                      |  |                                    |   |
|--------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> None        | <input type="checkbox"/> Limb Weakness | <input type="checkbox"/> Confused  | <input type="checkbox"/> Loss of Memory     |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Walking |

**Psychiatric**

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> None       | <input type="checkbox"/> Suicidal           | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Disturbed Sleep |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Change in Personality |  |

**Endocrine**

- |                                       |  |                                       |                                      |
|---------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None         | <input type="checkbox"/> Hair Loss       | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Feeling Weak | <input type="checkbox"/> Deepening Voice |                                       |                                      |

**Hem/Lymph**

- |                               |  |  |   |
|-------------------------------|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Swollen Glands |
|-------------------------------|--|--|---|

**AUTHORIZATION AND RELEASE TO BE PHOTOGRAPHED  
FOR ELECTRONIC MEDICAL RECORDS**

I authorize Woodlands Cancer Institute (WCI), a division of American Oncology Partners, P.A. (AOP), to take my photograph (digital camera/video may be used). These photos may then be placed in my WCI/AOP electronic medical record for identification purposes and/or medical documentation.

By signing this, I verify that I have received a copy of this authorization form for my records.

---

Patient Name (Print)

---

Patient or Guarantor (Signature)

---

Date

## REQUEST FOR RELEASE OF RECORDS

I, \_\_\_\_\_, request a copy of my complete medical record from the office of:

\_\_\_\_\_

Name and address of practitioner

**To be sent to Woodlands Cancer Institute:** *(Internal use)*

\_\_\_\_\_

Address, City, State, Zip Code

\_\_\_\_\_

Fax/Telephone Number

\_\_\_\_\_ I give permission to release my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

It is my understanding that by signing this authorization for release of my records, I am giving permission for Woodlands Cancer Institute (WCI), a division of American Oncology Partners, P.A. (AOP), to receive 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 is valid indefinitely until there is written communication received to revoke.

\_\_\_\_\_DISCLAIMER: Not signing does not prevent me from receiving care.

\_\_\_\_\_

Patient Name (Print)

\_\_\_\_\_

Date

\_\_\_\_\_

Patient Date of Birth

\_\_\_\_\_

Patient or Guarantor (Signature)

\_\_\_\_\_

Date



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

---

### CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

I give permission to the employees of Woodlands Cancer Institute (WCI), a division of American Oncology Partners, P.A. (AOP), to disclose my Protected Health Information to me and the following individual(s):

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

---

### INSURANCE INFORMATION

**Primary Insurance Carrier:** \_\_\_\_\_

Name of primary policy holder: \_\_\_\_\_

Policy#/Group ID: \_\_\_\_\_

Policy holder's date of birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Does plan have prescription coverage?  Yes  No

**Secondary Insurance Carrier:** \_\_\_\_\_

Name of secondary policy holder: \_\_\_\_\_

Policy#/Group ID: \_\_\_\_\_

Policy holder's date of birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Does plan have prescription coverage?  Yes  No

**Pharmacy Insurance Carrier:** \_\_\_\_\_

Name of pharmacy policy holder: \_\_\_\_\_

Policy#/Bin# \_\_\_\_\_

I certify that the information provided is accurate. I will notify Woodlands Cancer Institute (WCI), a division of American Oncology Partners, P.A. (AOP), of any changes as soon as they become available. I understand that it is my responsibility to update us of any changes to my insurance plan or I may be held liable for the full balance of my treatment.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Woodlands Cancer Institute (WCI), a division of American Oncology Partners, P.A. (AOP), Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any WCI/AOP facility or by submitting a request in writing to the corporate office at Woodlands Cancer Institute, a division of American Oncology Partners, P.A., 14543 Global Parkway, Suite 110, Fort Myers, FL 33913.

You may also view and/or print a copy of the Notice of Privacy Practices by visiting [AONcology.com/policies/WCI\\_NPP.pdf](http://AONcology.com/policies/WCI_NPP.pdf)

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

\_\_\_\_\_  
Date

**ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICIES AGREEMENT**

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Woodlands Cancer Institute (WCI), a division of American Oncology Partners, P.A. (AOP), Financial Policies Agreement.

This notice is available in hard copy by verbally requesting a copy at the front desk of any WCI/AOP facility or by submitting a request in writing to the corporate office at Woodlands Cancer Institute, a division of American Oncology Partners, P.A., 14543 Global Parkway, Suite 110, Fort Myers, FL 33913.

You may also view and/or print a copy of the Financial Policies Agreement by visiting [AONcology.com/policies/WCI\\_FPA.pdf](http://AONcology.com/policies/WCI_FPA.pdf)

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guarantor (Signature)

\_\_\_\_\_  
Date

By signing below, I authorize Woodlands Cancer Institute (WCI), a division of American Oncology Partners, P.A. (AOP), its affiliate and subsidiary entities, and AON Pharmacy, LLC (and any authorized WCI/AOP texting/email service vendor) to contact me by SMS text message or email for health-related notifications, including appointment reminders, billing communications, and to provide feedback to serve me better.

I understand that I may be receiving communications related to my information (name and email address) for marketing purposes, including from third parties and/or an online resource for patients to provide feedback regarding my care. I understand that message/data rates may apply to messages sent by WCI/AOP under my cell phone plan.

I know that I am under no obligation to authorize WCI/AOP to send me text messages and/or email. I may opt-out of receiving these communications at any time by responding with "STOP" or by unsubscribing.

I understand that text messages and/or email are not a substitute for professional or medical attention.

By signing below, I indicate I am the person legally responsible for all use of mobile and/or email accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services and email notifications.

PLEASE MARK THE FOLLOWING:

- I consent to receiving information via text and/or email. I understand I can withdraw my consent at any time.  
Text Cell # \_\_\_\_\_ Email \_\_\_\_\_
- I do not consent to receiving any information via text and/or email. I understand that I can change my mind and provide consent later.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (Signature)