OREGON SURGICAL WELLNESS (OSW)
WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
PATIENT DEMOGRAPHICS

PLEASE COMPLETE THE ENTIRE FORM

## Patient Information

| Today's Date: | Date of Birth: | Social Security Number: | |
|---|---|---|---|
| Legal Last Name: | Legal First Name: | Middle Name: | Preferred Name: |
| Referring Physician: | | Referring Physician Phone Number: | |
| Primary Care Physician: | | Primary Care Physician Phone Number: | |

## Patient Contact Information

Home Address (Street, City, State, Zip):

Mailing Address (Street, City, State, Zip):
☐ Same as the home address

| Phone:<br>Is this a cell phone? ☐ Yes ☐ No | Alternate Phone:<br>Is this a cell phone? ☐ Yes ☐No |
|---|---|
| Email Address: | Preferred Contact Method:<br>☐ Phone ☐ Alternate Phone ☐ Email ☐ Patient Portal |

## Patient Demographics

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Choose not to disclose

| Preferred Pronouns:<br>☐ She, Her, Hers<br>☐ He, Him, His<br>☐ They, them, theirs<br>☐ Other, please describe<br>_____<br>☐ Choose not to disclose | Gender Identity:<br>☐ Female<br>☐ Male<br>☐ Transgender Male (FTM)<br>☐ Transgender Female (MTF)<br>☐ Genderqueer/Non-binary<br>☐ Other, please describe<br>_____<br>☐ Choose not to disclose | Sexual Orientation:<br>☐ Straight or Heterosexual<br>☐ Lesbian, Gay, Homosexual<br>☐ Bisexual<br>☐ Other, please describe<br>_____<br>☐ Unknown<br>☐ Choose not to disclose | Sex (Assigned at Birth):<br>☐ Female<br>☐ Male<br>☐ Unknown |
|---|---|---|---|

| Race:<br>☐ American Indian or Alaska Native<br>☐ Asian<br>☐ Black or African American<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ White<br>☐ Other Race, please specify _____<br>☐ Choose not to disclose | Ethnicity:<br>☐ Hispanic or Latino<br>☐ Not Hispanic or Latino<br>☐ Unknown<br>☐ Other, please specify _____<br>☐ Choose not to disclose |
|---|---|

| Preferred Language: | Preferred Language for Written Documents: | Do you need a medical interpreter at appointments at no cost?<br>☐ Yes, specify language _____<br>☐ No |
|---|---|---|
| Occupation and Employer: | Employment Status: ☐ Employed ☐ Unemployed<br>☐ Retired ☐Student (Full) ☐ Student (Part)<br>☐ Choose not to disclose | |

OREGON SURGICAL WELLNESS (OSW)
WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
ONCOLOGY ASSOCIATES OF OREGON
ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

PLEASE COMPLETE THE ENTIRE FORM

| Patient Information | | | |
|---|---|---|---|
| Legal Last Name: | Legal First Name: | Middle Initial: | Date of Birth: |
| Billing Address (Street, City, State, Zip): | | | |

| Primary Insurance Information | | |
|---|---|---|
| Company: | Subscriber Name: | Subscriber Date of Birth: |
| Group Number: | ID/Policy Number: | |

| Secondary Insurance Information | | |
|---|---|---|
| Company: | Subscriber Name: | Subscriber Date of Birth: |
| Group Number: | ID/Policy Number: | |

| Tertiary Insurance Information | | |
|---|---|---|
| Company: | Subscriber Name: | Subscriber Date of Birth: |
| Group Number: | ID/Policy Number: | |

**Assignment of Benefits, Authorization to Release Medical Information:**

I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Willamette Valley Cancer Institute and Research Center and Oncology Associates of Oregon (collectively "WVCI") for any services furnished to me by Oregon Surgical Wellness (OSW), and I hereby assign to WVCI all assignable rights to payment for services rendered by OSW, including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to WVCI. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, or other healthcare providers assisting in my medical care. I understand and agree that my health information may be used and disclosed by OSW, WVCI, other providers, and insurers for treatment, payment and healthcare operations purposes.

I understand that in order for OSW/WVCI to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies, these transmissions are done in a safe manner that protects the privacy of personal information. I agree that OSW/WVCI may request and use my prescription history from other healthcare provides or third-party payors for treatment purposes as required by the above-mentioned federal initiative. I authorize OSW/WVCI to obtain my prescription history.

FINANCIAL AGREEMENT:
I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered.

I have read and agree to the provisions on this form and accept the terms. A duplicate of this form is considered the same as original.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

| Patient Signature:<br><br>(for patients 17 years of age or younger, parent or guardian MUST sign) | Relationship to Patient: |
|---|---|
| Printed Name: | Date: |

OREGON SURGICAL WELLNESS (OSW)
WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
ONCOLOGY ASSOCIATES OF OREGON
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**Oregon Surgical Wellness (OSW), a division of** Willamette Valley Cancer Institute and Research Center (WVCI)**,** has a responsibility to protect the privacy of your health care information. OSW also has a responsibility to give a Notice of Privacy Practices that describes:

- how your health care information may be used and shared
- how you can get your health care information
- whom to reach if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time. You may call OSW at 541-**735-3778** to get an up-to-date copy of the notice or to ask questions. This form will be retained in your records.

By my signature below, I agree that I have received the Notice of Privacy Practices of **Oregon Surgical Wellness:**

Printed Patient Legal Name – First, Middle, Last

Signature of Patient or Patient's Personal Representative Date Time

*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 Phone Number

| FOR INTERNAL USE ONLY | |
|---|---|
| *If acknowledgment was not obtained, please state the reason:* | |
| | |
| | |
| PRINTED OSW EMPLOYEE NAME | SIGNATURE OF OSW EMPLOYEE |

# User Electronic Mail Authorization Form
## Patient Portal: Ontada Health©

Ontada Health©, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Ontada Health© Portal. Please look for an email from Ontada Health© promptly after submitting this form.

For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

### Terms

You are receiving access to the Ontada Health© Portal the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

_____ Patient Name (First Name, Middle Initial, Last Name)

_____ Email Address of Patient/Authorized User

_____ Date of Birth of Patient

_____ Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

_____ Patient's Designee's Name (Printed)

_____ Patient's Designee's Signature

_____ Patient's Medical Record Number

_____ Patient's Signature

_____ Date

_____ Signature of Practice Staff [confirming user's identity and authority]

_____ Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient

STAFF USE ONLY

RECEIVING STAFF INITIALS: _____ PATIENT MRN: _____ COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK

☐ PATIENT DECLINED PORTAL ACCESS ☐ EMAIL IN PMS OR IKM SEPTEMBER 2023 VERSION 1.1

3rd PARTY ACCESS ☐ NO ☐ YES

Oregon Surgical Wellness (OSW)
Willamette Valley Cancer Institute and Research Center (WVCI)

# PATIENT CONSENT FOR PRACTICE TO COMMUNICATE WITH OTHERS

**Print Patient's Legal Name – First, Middle Initial, Last** _____ **Date of Birth** _____

**(Home/Cell) Phone Number** _____ **(Work) Phone Number** _____

## 1. Alternate Contact Information Authorization

OSW, a Division of WVCI has my Authorization to:

| | | |
|---|---|---|
| Leave medical information on my home/cell voicemail | Y | N |
| Contact me at my place of employment | Y | N |
| Leave medical information on voicemail at my place of employment | Y | N |

## 2. Family / Friends Release of Information Authorization

I authorize OSW to speak with, and disclose my health information to, the following person(s) regarding my medical care and treatment and payment for those services.

| Name | Relationship to Patient | Phone Number | Emergency Contact? |
|---|---|---|---|
| | | | Y / N |
| | | | Y / N |
| | | | Y / N |
| | | | Y / N |
| | | | Y / N |

## 3. Surrogate Decision Maker

If I am unable to make healthcare decisions for myself, my surrogate decision maker is named below and OSW can contact this individual in case of an emergency.

| Name of Health Care Surrogate Decision Maker | Relationship to Patient | Phone Number |
|---|---|---|
| | | |

## 4. Validation and Signature

I understand that I can change this list at any time by notifying OSW in writing. Written revisions will not affect any action taken in reliance on this consent before the written notice was received.

Signature of Patient _____ 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 _____

Oregon Surgical Wellness

# Medical History Form

WVCI Willamette Valley Cancer Institute and Research Center

**Today's Date: _____ Patient Name: _____ Date of Birth: _____**

Primary Care Physician: _____ Referring Physician: _____

**Personal Medical History:** Have you ever been diagnosed with the following? (Please check)

- ☐ **Cancer**
- ☐ **Heart Disease/CHF**
- ☐ High Blood Pressure
- ☐ **Blood Disorders**
- ☐ **Anemia**
- ☐ **Blood Clots**
- ☐ Neurological disease
- ☐ **Epilepsy/seizures**
- ☐ **Stroke**
- ☐ Migraines
- ☐ **Lung Disease**
- ☐ **Pneumonia**
- ☐ Asthma
- ☐ Asbestos Exposure
- ☐ Tuberculosis
- ☐ **Emphysema/COPD**
- ☐ **Liver Disease**
- ☐ **Hepatitis**
- ☐ **Pancreatic disease**
- ☐ Inflammatory Bowel Disease
- ☐ Gallbladder disease
- ☐ **Kidney Disease**
- ☐ Thyroid Problems
- ☐ **Diabetes**
- ☐ **Alcohol/Drug dependence**
- ☐ **Mental Health Issues**
- ☐ **Rheumatoid Arthritis**
- ☐ **Lupus/autoimmune**
- ☐ **Multiple Sclerosis**
- ☐ **HIV/AIDS**
- ☐ Osteoarthritis
- ☐ **Skin ulcers**

Other: _____

**Surgical History:** List operations you have had and the reason for surgery. Please give approximate date and list in chronological order, if possible, including tonsils, C-Sections, etc.

1. _____
2. _____
3. _____
4. _____

**Hospitalizations, Serious illness, and injuries:** Please give approximate date and list in chronological order if possible.

1. _____
2. _____
3. _____
4. _____

**Have you had a blood transfusion?** ☐Yes ☐No

**Family History:**

| Relationship | Please circle | Age | If Deceased: Age at Death and Cause of Death | Significant Medical History |
|---|---|---|---|---|
| **Father** | Alive Deceased | | | |
| **Mother** | Alive Deceased | | | |
| **Sibling 1:** | Alive Deceased | | | |
| **Sibling 2:** | Alive Deceased | | | |
| **Sibling 3:** | Alive Deceased | | | |
| **Sibling 4:** | Alive Deceased | | | |

***Has any of your extended family ever had any of the following (including cousins, grandparents, aunts/uncles):***

| Relationship | Maternal or Paternal | Age at Onset | History of Cancer (If yes, indicate type) | History of blood clots (If yes, where) | History of excessive bleeding (if yes, where) |
|---|---|---|---|---|---|
| Grandmother | | | | | |
| Grandfather | | | | | |
| Grandmother | | | | | |
| Grandfather | | | | | |
| Aunt/Uncle | | | | | |
| Aunt/Uncle | | | | | |
| Cousin | | | | | |

**Today's Date: _____ Patient Name: _____ Date of Birth: _____**

Do you have an advance directive for healthcare decisions? ☐Yes ☐No

**Social History:**

Do you use nicotine? ☐Yes ☐No How much/how long: _____ Quit/When: _____
What type? ☐Cigarettes ☐Cigars ☐Chew
Do you drink alcohol? ☐Yes ☐No How much/how long: _____ Quit/When: _____
Have you used drugs? ☐Yes ☐No What type: _____Quit/When: _____
Marital Status: ☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐Widowed
Living Situation: ☐ Alone ☐Roommate ☐Spouse/Partner ☐Significant Other ☐With Children ☐Parents

**Immunizations:** Please give date of most recent vaccination or series completion date.

Influenza: _____Pneumonia: _____ Hepatitis A: _____ Hepatitis B: _____
Shingles: _____ Tetanus: _____ HPV: _____ Meningococcal: _____

**Preventative Health:**

Have you ever had a colonoscopy? ☐Yes ☐No
Date/location of last colonoscopy: _____Findings:_____
Have you ever had bone density test? ☐Yes ☐No
Date/location of last test: _____ Findings: _____
Have you had a mammogram? ☐Yes ☐No
Date/location of last mammogram: _____Findings:_____

**FOR WOMEN**

**Menstrual History:**

Date of last period: _____ Age periods began: _____ Age of Menopause: _____
Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? ☐Yes ☐No
Number of live births: _____ Number of pregnancies: _____
Current birth control method: _____ Are you interested in preserving your fertility? ☐Yes ☐No

**Medication Allergies:** List medication and reaction.

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Medication List:** List medication, dose and how often you take it. Include non-prescriptive items and supplements.

| Name | Dose | Frequency | Name | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |

Oregon Surgical Wellness

# Review of Symptoms

WVCI WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER

**Today's Date: _____ Patient Name: _____ Date of Birth: _____**

**Please review and mark any current symptoms or problems you have experienced in the last six months.**

**General:**
☐Loss of appetite
☐Fever/chills
☐Night sweats
☐Weakness
☐Fatigue

**Hematologic:**
☐Abnormal bleeding
☐Abnormal bruising
☐Swollen glands

**Allergies/immunologic:**
☐Seasonal allergies
☐Food allergy_____
☐Sinus Problems
☐Frequent infections

**Skin:**
☐Slow healing
☐Rash
☐Nail change
☐Change in skin or mole
☐Other _____

**Breasts:**
☐Discharge/bleeding
☐Lump
☐Pain

**Eyes:**
☐Change in vision
☐Eye infection
☐Eye pain

**Ears/Nose/Throat:**
☐Hearing loss
☐Ringing in ears
☐Bleeding gums
☐Hoarseness
☐Neck swelling/lumps
☐Nose bleeds
☐Dental Issues

**Cardiovascular:**
☐Chest discomfort/pain
☐Irregular heart beat
☐Swollen hands or feet
☐Racing heart

**Respiratory:**
☐Shortness of breath
☐Cough
☐Wheezing
☐Cough up blood
☐Difficulty breathing

**Gastrointestinal:**
☐Bloody or black stools
☐Constipation
☐Difficulty swallowing
☐Heartburn/esophageal reflux
☐Diarrhea
☐Nausea
☐Vomiting
☐Abdominal Pain
☐Pain with bowel movements
☐Jaundice

**Urinary:**
☐Blood in urine
☐Frequency
☐Difficulty urinating
☐Pain or burning with urination
☐Incontinence

**Musculoskeletal:**
☐Back or neck pain
☐Painful or stiff joints
☐Bone pain, Site: _____
☐Arthritis

**Mental Health:**
☐Depressed or sad
☐Anxiety
☐Sleep issues
☐Suicidal thoughts

**Neurological:**
☐Headaches
☐Dizziness
☐Fainting
☐Loss of balance
☐Difficulty speaking
☐Loss of sensation
☐Memory Issues
☐Seizures

**Endocrine:**
☐Weight loss
☐Weight gain
☐Excessive thirst
☐Heat/cold intolerance

FOR WOMEN
**Gynecological:**
☐Irregular menstrual periods
☐Hot flashes
☐Menopause
☐Heavy menstrual bleeding