Patient Information **Date** _____

Patient Name (First) _____ (M.I.) _____ (Last) _____

Date of Birth _____ SSN _____

Gender ☐ Male ☐ Female ☐ Transgender-Male ☐ Transgender-Female

Marital Status _____ Race _____ Ethnicity _____ Preferred Language _____

Patient Address _____ City _____

Zip Code _____ State _____ Home Phone _____ Cell Phone _____

Employer _____ Work phone _____

Emergency Contact (outside home) Name _____ Relation _____

Phone _____

Insurance Holder Information or Guarantor Information Patient Relation *(i.e. self, husband, wife, father, mother)*

Guarantor Name (First) _____ (M.I.) _____ (Last) _____

Date of Birth _____ SSN _____ **Employer** _____

Guarantor Address _____ City _____

Zip Code _____ State _____ Home Phone _____

PAYMENT POLICY: Payment or partial payment is required on the day of visit.

Authorization for Assignment of Insurance Benefits, Information Release, and Financial Responsibility

I authorize the payment of medical benefits be made on my behalf directly to the Practice for any services furnished to me by the physician or practice. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize the release to my insurance company any and all information concerning heath care, advice, or treatment provided to me necessary for processing insurance claims. I understand if my insurance requires a prior authorization for office visits, procedures, tests, or services, it is my responsibility to make sure the authorization is obtained prior to the visit, procedure, surgery, test, or service being performed. I understand that if I am seen without an authorization I will be considered a self-pay patient and will be required to pay in full for all services performed. **I agree to pay any and all charges that are not covered or are not paid by my insurance plan(s).**

If you have insurance coverage, we ask that you pay the amount the insurance does not cover, such as the deductible and co-insurance. All accounts are to be paid in full within 90 days from date of service. Payment(s) can be made by cash, check, or MasterCard, Visa, Discover or American Express. If account is not paid, it will be placed with our collection agency. If a check is returned to us for any reason, a $30.00 service charge will be added to your account.

As a courtesy, our office will file your insurance. Your insurance policy is a contract between you and your insurance company. You are responsible for payment of all services rendered, whether or not your insurance company has paid. It is important to understand that your insurance company may not pay all of the charges and the difference between what they pay and your total charges is your responsibility. Our office can help you with problems which may arise with your claim, but our office does not accept the responsibility for negotiating a settlement on a disputed claim.

I have read the above payment policy and understand that I am responsible for payment of my account. Assignment: I assign and request payment of medical benefits to physician for services.

_____ _____

Patient/Guardian Signature Date

Primary Care Physician _____

Please list physicians other than your referring physician and primary care physician whom you would like to receive a copy of your pathology report.

Name	City/State

Outpatient Cytopathology center

May the OCC staff contact you to provide you with appointment reminders or for the purpose of advancing medical education through clinical and surgical follow ups? Below is a list of persons with whom we have permission to speak to and/or release medical records to on your behalf.
Please circle all that apply.

A. You may call me to confirm appointments and/or obtain medical follow-up information? Y N
You may contact me at the designated number(s).. Home Cell Work

B. If you would like anyone other than yourself to have access to your information, please complete the section below. I understand that authorization for release of information can only be revoked upon written notice. (Circle the type of information which you authorize us to share).

_____ Account Medical Power of Attorney
Name Relationship Phone#

C. May we leave a message on your Voicemail/Answering Machine? Y N

D. I do not have a telephone number. You may call _____ at
Name Relationship

_____.
Phone#

Patient/Guardian name: _____ Date: _____

Patient/Guardian Signature: _____

This form is valid until further notice, until modified or replaced at the patient's request.

HIPAA Notice of Privacy Practices Acknowledgment

I have had access to or received, read, and understand your Notice of Privacy Practices and the Notice of Nondiscrimination Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the Practice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Guardian name: _____ Date: _____

Patient/Guardian Signature: _____

Outpatient Cytopathology center

Authorization to Release Medical Records/Information

Physician to provide records: _____

Patient's name: _____

Social Security #: _____ DOB: _____

Person/Facility to receive records: Outpatient Cytopathology Center

Address: 2400 Susannah Street Suite A

City, State, Zip: Johnson City TN 37601

Phone #: 423-283-4734 FAX #: 423-283-4736

(Please initial one line)

Release these records: Initials

1. Only records generated by this facility (not including records received from other sources) _____
2. Only some portion of records maintained at this facility (dates of treatment, etc., specify below) _____
3. All medical records at this facility _____

Expiration or revocation of authorization- I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies- A copy of this authorization may be utilized with the same effectiveness as an original.

_____ Patient name (print):

_____ Person authorized to sign for patient (print):

_____ Patient's signature

_____ Signature
Relationship to patient

Date: _____

Date: _____

Patient Name: _____ OCC# _____

Review of Systems

(please check any recent symptoms)

General
☐ Weight loss or gain ☐ Fever or chills ☐ Fatigue

Skin
☐ Rashes ☐ Itching ☐ Dryness

Head
☐ Headache ☐ Head injury

Ears
☐ Decreased hearing ☐ Earache ☐ Drainage

Eyes
☐ Glasses or contacts ☐ Blurry or double vision ☐ Dry eyes

Nose
☐ Stuffiness ☐ Itching ☐ Nosebleeds ☐ Discharge
☐ Hay fever ☐ Sinus pain

Mouth
☐ Bad/sore teeth ☐ Gum disease ☐ Dry mouth
☐ Dentures or Bridges

Throat
☐ Sore tongue ☐ Sore throat ☐ Hoarseness

Neck
☐ Lumps ☐ Pain ☐ Stiffness

Breasts
☐ Lumps ☐ Pain ☐ Nipple discharge ☐ Implants ☐ Breastfeeding

Respiratory
☐ Cough ☐ Coughing up blood ☐ Wheezing
☐ Shortness of breath ☐ Painful breathing

PLEASE TURN TO THE OTHER SIDE OF PAGE

Cardiovascular

- ☐ Chest pain or discomfort
- ☐ Shortness of breath with activity
- ☐ Shortness of breath lying down
- ☐ Palpitations
- ☐ Swelling (legs/feet, arms/hands)

Gastrointestinal

- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Yellow eyes or skin (jaundice)

Urinary

- ☐ Blood in urine
- ☐ Painful urination
- ☐ Increase frequency

Genital

Male

- ☐ Sores
- ☐ Lumps
- ☐ Abnormal drainage

Female

- ☐ Itching or rash
- ☐ Pain
- ☐ Lumps
- ☐ Abnormal discharge

Musculoskeletal

- ☐ Muscle or joint pain
- ☐ Back pain
- ☐ Swelling of joints

Neurologic

- ☐ Seizures
- ☐ Numbness
- ☐ Tingling

Hematologic

- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine

- ☐ Constipation or Diarrhea
- ☐ Achy bones
- ☐ Diabetes
- ☐ Feel Hot all the time
- ☐ Feel Cold all the time

Psychiatric

- ☐ Nervousness
- ☐ Memory loss
- ☐ Depression

Physician Review: _____

Patient Name: _____ **OCC#** _____

Patient Medical History:
Allergies: _____

Current Medications (or attach list): _____

_____

_____

_____

Personal History of Cancer: (type, physician, year): _____

_____

Previous Surgeries or Biopsies (type,, year): _____

_____

_____

Important Medical History: _____

_____

_____

Social History:

Smoking ☐ Yes ☐ No How many years? _____ pack/day _____
When did you quit? _____
Chew Tobacco ☐ Yes ☐ No How many years? _____ How much? _____
When did you quit? _____
Alcohol ☐ Yes ☐ No Drinks/day _____ or drinks/week _____
When did you quit? _____
Illicit Drug Use ☐ Yes ☐ No _____
During the past 30 days have you been prescribed a controlled substance or narcotic medication by another physician ☐ Yes ☐ No
Exposure to toxic chemicals, radiation, toxic materials (circle any that apply).
Birthplace: _____
Do you work? ☐ Yes ☐ No If yes, occupation: _____

Family History of Cancer (mother, father, brother, sister, etc; cancer type):

_____

_____

_____

Dr. Review: _____