



### Patient Information

Today's Date: \_\_\_\_\_

Full Name (Last, First, MI): \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female SSN: \_\_\_\_\_

Address (Street, City, Zip code): \_\_\_\_\_

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

Phone (check preferred contact):  Home \_\_\_\_\_  Cell \_\_\_\_\_  
May we leave a message on your answering machine / voicemail?  Yes  No

Employed:  No  Yes: Occupation \_\_\_\_\_ Work phone \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Emergency Contact Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Power of Attorney (if applicable): \_\_\_\_\_ Relationship \_\_\_\_\_

**Race:**

- African American  Caucasian  Unknown  Other \_\_\_\_\_
- Asian  Hispanic  Decline to provide

**Ethnicity:**

- Hispanic or Latino  Not Hispanic or Latino

**Preferred Language:**

- English  Spanish  Other \_\_\_\_\_

**List the physicians you would like to receive communication:**

Name	Specialty	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



9 Centre Drive, Suite 115  
Monroe, NJ 08831  
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Patient Name: \_\_\_\_\_

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

Do you have an Advanced Directive (Living Will)?  Yes  No

Do you have a previous diagnosis of cancer?  No  Yes, type/year:

Medical Problems	Surgery: Type and date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Please check any Medical Devices / Implants:**

- Pacemaker
- Defibrillator
- Infusion Port
- Insulin pump
- Dialysis access / catheter
- VP Shunt

Date of last Flu vaccine: \_\_\_\_\_ Date of Pneumococcal vaccine: \_\_\_\_\_

Do you currently, or, have you ever smoked or used tobacco?  No  Yes

If Yes, type \_\_\_\_\_ How much per day \_\_\_\_\_ # of years \_\_\_\_\_ Year quit \_\_\_\_\_

Do you drink alcohol?  No  Yes If Yes, what kind \_\_\_\_\_ How many drinks per day \_\_\_\_\_

Were you ever exposed to any occupational hazards (such as asbestos, chemicals, coal dust)?

\_\_\_\_\_

**FEMALE PATIENTS ONLY:**

Last mammogram: \_\_\_\_\_ Last Bone Density Scan: \_\_\_\_\_

Last pap smear: \_\_\_\_\_ Age of menses: \_\_\_\_\_ Age at menopause: \_\_\_\_\_

Age at 1<sup>st</sup> pregnancy: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of Deliveries: \_\_\_\_\_

History of hormone replacement therapy  No  Yes If yes, how many years? \_\_\_\_\_

History of oral contraceptive use?  No  Yes If yes, how many years? \_\_\_\_\_



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

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

**Medications:** Please list any medications you are taking at this time (including hormones and vitamins)

Check if copy of medication list is attached

Medication	Dose	How often	How taken (oral/injection/topical)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

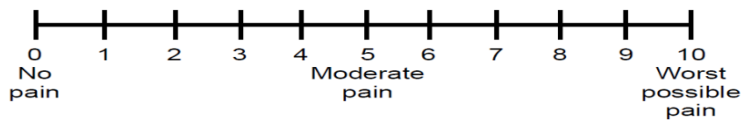
Pharmacy Address: \_\_\_\_\_

Do you have a latex allergy?  No  Yes      Do you have an allergy to IV contrast?  No  Yes

Do you have any medication allergies?  No  Yes - please list below:

Medication Allergy	Reaction
_____	_____
_____	_____
_____	_____

Pain Rating - If you have pain, where is it located? \_\_\_\_\_



**Nursing Notes (For Office Use Only):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

RN initials \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Review of Systems:** *Please check any symptoms you are currently experiencing:*

**Constitutional**

- Fatigue
- Fever
- Chills
- Night sweats
- Difficulty Sleeping
- Weight loss >10 lbs.
- Weight gain >10 lbs.

**Head and Neck**

- Hearing changes
- Eye pain
- Ear pain
- Oral sores
- Dry Mouth
- Change in voice
- Sore throat
- Difficulty swallowing
- Jaw pain

**Skin**

- Itching
- Rashes
- New or changed mole
- Unhealed sores
- Nail changes
- Change in skin color

**Cardiovascular**

- Chest pain
- Palpitations
- Dizziness or fainting
- Leg swelling

**Respiratory**

- Shortness of breath
- Wheezing
- Cough
- Coughing up blood

**Gastrointestinal**

- Loss of appetite
- Indigestion/heartburn
- Bloating
- Abdominal pain
- Nausea/vomiting
- Diarrhea
- Constipation
- Rectal bleeding
- Incontinence
- Date of last colonoscopy: \_\_\_\_\_

**Neurological**

- Headaches
- Visual changes
- Dizziness
- Memory loss
- Confusion
- Numbness/tingling
- Muscle weakness
- Unsteady gait

**Lymphatics**

- Easy bruising
- Swollen glands
- Swelling of arm/leg

**Endocrine**

- Increased thirst
- Increased urination
- Hair changes
- Cold intolerance

**Psychiatric**

- Anxiety
- Depression

**Musculoskeletal**

- Joint swelling
- Muscle or joint pains
- Back pain
- Bone pain

**Genitourinary**

- Frequent urination
- Urinary urgency
- Urinary burning
- Blood in urine
- Incontinence

**GU - Male**

- Impotence
- Testicular pain
- Penile pain

**Breast**

- Breast Mass
- Breast Pain
- Nipple Discharge

**Have any members of your family (blood relatives) had cancer?**  No  Yes, please list:

Relationship	Cancer	If deceased, age	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



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

**Primary Insurance Carrier**

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

Policy holder's Date of Birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

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

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

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

Does plan have prescription coverage?  Yes  No

**Secondary Insurance Carrier**

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

Policy holder's Date of Birth: \_\_\_\_\_ Policy holder's SS#: \_\_\_\_\_

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

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

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

Does plan have prescription coverage?  Yes  No

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**Where did you learn about Princeton Radiation Oncology?**

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Physician Referral | <input type="checkbox"/> Family / Friends | <input type="checkbox"/> Insurer      |
| <input type="checkbox"/> Advertisement      | <input type="checkbox"/> Internet Search  | <input type="checkbox"/> RCCA Website |
- 

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible.

I will notify the doctor/staff to any changes or additions at subsequent visits.

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



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## REQUEST FOR RELEASE OF MEDICAL RECORDS

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

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Name and Address of Practitioner / Facility

To be sent to: Princeton Radiation Oncology  
9 Centre Drive, Suite 115  
Monroe, NJ 08831  
Phone: 609-655-5755  
FAX: 609-655-5725

I give permission to fax my medical records to the above listed person, company or medical facility. I understand 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 Princeton Radiation Oncology to receive copies of any medical, psychiatric, 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 will expire 1 year after the date below or sooner at my election.

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Print Patient Name

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Date

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Signature Patient, Parent, or Legal Guardian/Representative

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Date

---

Witness

---

Date

Princeton Radiation Oncology / Regional Cancer Care Associates LLC ("RCCA") is committed to protecting the privacy of individual health information in compliance with the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act (both Acts together, "HIPAA") and the regulations promulgated there under. These policies and procedures apply to protected health information ("PHI") created, received, maintained or transmitted by RCCA after April 13, 2013.