KATMAI ONCOLOGY GROUP
www.katmaioncology.com

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Soldotna Office
247 N. Fireweed Street, Suite B
Soldotna, AK 99669
(907) 262-1310
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PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

Patient Name: _____ **Date of Birth:** _____
First M Last

Social Security #: _____-_____-_____ **Gender:** M ☐ F ☐ **Marital Status:** S ☐ M ☐ W ☐ D ☐

Race: _____ **Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Language:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Ph #: _____ **Cell #:** _____ **E-mail:** _____

Employer: _____ **Work Phone:** _____

Preferred Contact Method: **Home** ☐ **Cell** ☐ **Work** ☐ **Message OK:** **Home** ☐ **Cell** ☐ **Work** ☐

Referring Physician: _____ **Primary Care Physician:** _____

Preferred Pharmacy: _____ **Location:** _____

SPOUSE

Name: _____ **Date of Birth:** _____

Social Security #: _____ **Address:** _____

City/State: _____ **Zip:** _____ **Home Phone:** _____

Employer: _____ **Work Phone:** _____

EMERGENCY

Name/Relationship	Phone	Allowed to talk with about:
_____	_____	☐ Medical ☐ Financial
_____	_____	☐ Medical ☐ Financial
_____	_____	☐ Medical ☐ Financial

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD TO COPY)

PRIMARY

Insurance Co.: _____ **Policy Holder/Relationship:** _____

Policy Holder's DOB: _____ **Policy Holder's SSN:** _____

SECONDARY

Insurance Co.: _____ **Policy Holder/Relationship:** _____

Policy Holder's DOB: _____ **Policy Holder's SSN:** _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Acknowledgement of Release of Medical Records and Payment Policy

Release of Medical Information

- I authorize Katmai Oncology Group to release and/or obtain any medical records concerning myself from/to any physician, hospital, or agency involved with my care.
- I authorize Katmai Oncology Group to download my prescription reimbursement history electronically.

Assignment of Medical Benefits

- I authorize my insurance carrier to assign all medical benefits, if applicable, to Katmai Oncology Group.
- I authorize release of medical information necessary to process all medical insurance claims.

Usual and Customary Rates

- We, Katmai Oncology Group, charge what is usual and customary for our area.
- I am responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment Policy

- Co-payments are to be collected at the time services are received. We accept cash, check, Visa, and MasterCard.
- All medical services provided are directly charged to the patient or responsible party.
- If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed.
- I will be responsible for any balance deemed patient responsibility/non-payable/non-covered by my insurance and billed accordingly.
- Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.
- If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
- I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me.
- This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.

_____ _____

(Patient's Signature – or legal representative) *(Date of signature)*

_____ _____

(Print Patient's Name) *(Legal representative's relationship to patient)*

KATMAI ONCOLOGY GROUP

Patient Medical and History Information Sheet

Name:_____ **Date of Birth:** _____ **Date:** _____

SYMPTOMS (check symptoms you currently have, or have had in the *recent* past)

Weight change in the past year: ☐ increase ☐ decrease By how much: _____

- ☐ Fever
- ☐ Night sweats
- ☐ Vision trouble
- ☐ Dizzy spells
- ☐ Severe headaches
- ☐ Hearing trouble
- ☐ Depression
- ☐ Cough
- ☐ Shortness of breath
  (If so, with what activity:_____)
- ☐ Blood in sputum
- ☐ Fast, irregular or slow pulse
- ☐ Chest pain or discomfort
- ☐ Swollen lymph nodes
- ☐ Trouble swallowing
- ☐ Trouble with appetite
- ☐ Trouble sleeping
- ☐ Abdominal pain or swelling
- ☐ Blood in vomit or stool
- ☐ Change in bowl habits
- ☐ Black bowel movements
- ☐ Diarrhea
- ☐ Frequent indigestion
- ☐ Nausea, vomiting
- ☐ Constipation
- ☐ Burning when passing urine
- ☐ Blood in urine
- ☐ Swelling in the legs
- ☐ Numbness/tingling
  (If so, where: _____)
- ☐ Joint or bone pain
  (If so, where: _____)
- ☐ Breast pain, lump, discharge
- ☐ Skin rashes
- ☐ Easy bruising or bleeding

Other symptoms of concern: _____

CONDITIONS (check conditions you have, or have had in the past)

- ☐ History of cancer
- ☐ Kidney disease
- ☐ Heart disease
- ☐ Stroke, seizure, or other neurological disorder
- ☐ Blood clot
- ☐ High blood pressure
- ☐ Goiter or thyroid trouble
- ☐ Lung disease
- ☐ Liver disease
- ☐ Mental health disorder
- ☐ Diabetes or sugar in urine
- ☐ Blood transfusion(s)

Surgeries/Injury/Hospitalization	When

PLEASE COMPLETE BOTH SIDES OF THIS FORM

ALLERGIES (i.e., medications, food(s), latex, dye, adhesive tape, bee stings, etc.) ☐ **None**

Allergy/Sensitivity	Reaction

FAMILY HISTORY (is there a history of cancer, blood disorders or other medical problems in your family?)

Family Member	Living Status	Age, now or at death	Medical Problem(s)	Cause of Death	If cancer, age at diagnosis
Mother	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Father	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Sibling ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Sibling ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Sibling ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Child ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Child ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Child ☐ M ☐ F	☐ Living ☐ Deceased				☐ Under 50 ☐ 50 & older
Other family members with cancer?			**Who:**	**Type:**	

PREVENTATIVE HEALTH MAINTENANCE

Female: Last mammogram: _____ Last pap smear: _____

Last colonoscopy: _____ Last bone density: _____

Male: Last prostate exam: _____ Last colonoscopy: _____

Last PSA screening: _____

SOCIAL HISTORY

Current occupation: _____ Previous occupation(s): _____

Marital status: ☐ Married ☐ Single ☐ Widow(ed) ☐ Divorced

Live with: ☐ Family ☐ Alone ☐ Other: _____

Tobacco use: ☐ Current ☐ Past Years: _____ Quit date: _____

Type: Cigarettes/cigars/pipe/chew/e-cigarette: _____ Packs per day/Amount: _____

Alcohol use: ☐ Yes ☐ No Drinks per week: _____

For Women:

Number of pregnancies: _____ Age at first pregnancy: _____ Number of children: _____

Age at first period: _____ Age at menopause: _____

Vaginal symptoms: ☐ Abnormal bleeding When: _____

☐ Other Describe: _____

ADVANCED CARE PLANNING

Do you have any of the following: Advanced Directive; Medical Power of Attorney; Living Will; Comfort One; etc?

☐ Yes *(if yes, please provide copies)* If No, would you like more information? ☐ Yes ☐ No

MEDICATION LIST

Name: _____

Please list all the medications you are taking, including herbs and supplements

	MEDICATION	DOSE	FREQUENCY	START DATE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

KATMAI ONCOLOGY GROUP

Patient Portal: My Care Plus
User Authorization Form

My Care Plus, 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.

You may use your own personal e-mail address, or assign an Authorized Designee's e-mail address to access the Portal. If you assign an Authorized Designee, they (and you) must understand that by signing this form, the listed e-mail address will be utilized for Portal purposes.

If you choose to sign-up for the Portal, you receive an e-mail with unique link that you will use to create a password in order to access your personal health record. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. Please contact your physician's office if you require a new link sent to your e-mail address.

Because personal 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 change email addresses, or if you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please print clearly.

☐ **I DO want to sign-up for the Patient Portal (please complete & sign below)**

OR

☐ **I do *NOT* want to sign-up for the Patient Portal**

_____
Printed Patient Name

_____
Date of Birth of Patient

_____
Email Address of Patient/Authorized Designee

_____
Patient's Signature

_____
Authorized Designee's Name

_____
Authorized Designee's Signature
(if available or applicable)

_____
Date

Staff Use Only *(initial when complete)*:

"Primary" E-mail in iKM_____	Patient Portal in iKM_____
Treatment Location in iKM_____	Invite sent via Portal_____

KATMAI ONCOLOGY GROUP

Consent for Unsecure E-mail / Text

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has standards for protecting the privacy and confidentiality of individuals health information. Katmai Oncology Group follows these laws and regulations by offering encrypted (secured) e-mail communication through the My Care Plus Patient Portal.

If you want to communicate with Katmai by unencrypted (unsecured) e-mail or text, your written consent is required. Unsecured communication sent through the internet or over the phone systems means that unauthorized persons may be able to access the information sent.

By answering "YES" you allow Katmai to communicate with you through unsecured methods, you are agreeing that Katmai and its staff are NOT liable for any losses, damages, costs, or expenses which are sustained, incurred, or required arising from the transmission of unsecured e-mails, texts, and / or attachments. This consent will remain effect until revoked in writing. It may be revoked in writing at any time.

Please indicate your choice below:

☐ **YES, I allow Katmai to send unsecured e-mail or text** *(please print clearly)*

☐ E-mail (use this e-mail address):_____

☐ Text (use this phone number): ( ) -

OR

☐ **NO, I do NOT allow Katmai to send unsecure e-mail or text**

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient's Signature Date

KATMAI
ONCOLOGY GROUP

Acknowledgement of Notice of Privacy Policy

By signing this form, I acknowledge that I received a copy of Katmai Oncology Group's Notice of Privacy Policy. I understand that I may request another copy of the policy at any time.

_____ _____

(Patient's Signature – or legal representative) *(Date of signature)*

_____ _____

(Print Patient's Name) *(Legal representative's relationship to patient)*