epic Care
Partners in Comprehensive Care

NEW PATIENT INTAKE QUESTIONNAIRE

Patient Name:	**Date of Birth:**	**MRN:**
Phone Number:	Email:	
Language if Interpreter Needed:	Ethnicity:	

REASON FOR VISIT:

Are you having any pain today?	Y	N	Severity of pain (1-10):
Are you on a pain contract?	Y	N	How long have you had this pain?
Location of pain:			Multiple sites ☐

ALLERGIES & MEDICATIONS

Are you allergic to any medicines / foods / dyes /materials?	Y	N	

If yes, what are you allergic to and what is the reaction?

Preferred Pharmacy:	Pharmacy Address & Phone #:

List medications including any vitamins, herbs, etc. you take (Attach or bring a list of meds):

Name / Dose/ Frequency	Name / Dose/ Frequency	Name / Dose/ Frequency
Name / Dose/ Frequency	Name / Dose/ Frequency	Name / Dose/ Frequency

FAMILY HISTORY ☐ Adopted ☐ Unknown

Any **blood** relatives with a history of cancer or other significant medical issue(s) (e.g., diabetes, hypertension, heart disease)?

SOCIAL HISTORY

Marital Status:	# Of Kids:	Occupation:		
ADVANCED CARE DIRECTIVE	Do you have one?	Y	N	

CARE TEAM I authorize the following individuals to inquire and speak on my behalf for ALL healthcare, insurance, and billing issues**

Primary Care Physician:	Name		Phone Number
Referring Physician:	Name		Phone Number
Others**:	Name	Caregiver / Spouse / POA	Phone Number
	Name	Caregiver / Spouse / POA	Phone Number

REVIEW OF SYSTEMS Have you experienced any of these in the past month?

	YES		YES		YES
Loss of appetite, weight loss	Y	Dental Problems	Y	Bleeding	Y
Fevers	Y	Hoarseness or Changes in Voice	Y	Shortness of Breath	Y
Chills	Y	Cough	Y	Sexual Difficulties	Y
Skin rash or itching	Y	Seizures	Y	Easy bruising	Y
Headaches	Y	Trouble Sleeping	Y	Chest pain	Y
Loss of balance or coordination	Y	Frequent indigestion or heartburn	Y	Abdominal pain	Y
Arm or leg weakness	Y	Nausea or vomiting	Y	Difficulty Swallowing	Y
Visual changes	Y	Bowel Movement Issues	Y	Sores	Y
Pain	Y	Urinary Issues	Y	Dizziness	Y
Hearing loss	Y	Jaundice	Y	Mood Changes, Depression	Y
Night sweats	Y	☐ **No, I have not had or have any of the conditions listed above**			

Patient Name: **Date of Birth:** **MRN:**

PAST MEDICAL HISTORY	YES	NO		YES	NO		YES	NO
Seasonal Allergies	Y	N	Lung Problems	Y	N	Thyroid Disease	Y	N
Anemia	Y	N	Dementia	Y	N	Tremors	Y	N
Anxiety	Y	N	Heart Burn	Y	N	Breast Issues	Y	N
Arthritis	Y	N	Diabetes Mellitus	Y	N	Stomach/Intestine Problems	Y	N
Asthma	Y	N	High Cholesterol	Y	N	Osteoporosis	Y	N
Autoimmune Disease	Y	N	High Blood Pressure	Y	N	Prostate Problems	Y	N
Mental Disorders	Y	N	Kidney Problems	Y	N	Infections (HIV, TB, etc.)	Y	N
Cancer	Y	N	Gout	Y	N	Skin Problems	Y	N
Heart Problems	Y	N	Migraines	Y	N	Hormone Problems	Y	N
Back Problems	Y	N	Nerve / Muscle Disease	Y	N	Cysts/Polycystic Ovary	Y	N
Genetic Mutations	Y	N	Bone Problems	Y	N	Substance Abuse	Y	N
Eye Problems	Y	N	Sleep Problems/Apnea	Y	N	Thyroid Disease	Y	N
Clotting Disorder	Y	N	Stroke	Y	N	Seizures	Y	N
Difficult Intubation	Y	N	Fibroids	Y	N	Fibromyalgia	Y	N

Other Medical History:

PAST SURGICAL HISTORY	YES	DATE		YES	DATE		YES	DATE
Abdominal Surgery	Y	Date	Ear Surgery	Y	Date	Transplanted Organ	Y	Date
Brain Surgery	Y	Date	Eye Surgery	Y	Date	Spine Surgery	Y	Date
Breast Surgery	Y	Date	Prostate Surgery	Y	Date	Thyroid Surgery	Y	Date
Heart Surgery	Y	Date	Fracture Surgery	Y	Date	Tonsillectomy	Y	Date
Cholecystectomy	Y	Date	Hernia Repair	Y	Date	Tubal Ligation	Y	Date
Dental Surgery	Y	Date	Hysterectomy	Y	Date	Weight Loss Surgery	Y	Date
Cosmetic Surgery	Y	Date	Joint Replacement	Y	Date	Vasectomy	Y	Date
C-Section	Y	Date	Ovary Removal	Y	Date	Vein Surgery	Y	Date
Amputation	Y	Date	Bone Marrow Transplant	Y	Date	Lung Surgery	Y	Date
Kidney Surgery	Y	Date	Implanted Device	Y	Date	Liver Surgery	Y	Date

Other Surgical History:

GYNECOLOGICAL / REPRODUCTIVE HISTORY (FEMALE PATIENTS ONLY)

Onset of menstruation (age): Age			Are your periods regular?	Y	N
Date of last menstrual period: Date			Age at menopause: Age		
Have you ever taken birth control pills?	Y	N	Do you/your partner use birth control?	Y	N
If yes, what type?			At what age did you start? Age	Stop? Age	
Have you ever used hormone replacement therapy?	Y	N	If yes, how long? From:	Until:	
Have you ever taken hormones for any other reason (e.g. Fertility drugs, DES, etc.?				Y	N
Is there any chance you could be pregnant?	Y	N	Are you planning to have children?	Y	N
Number of pregnancies: #			Number of live births: #		
Age at first delivery? Age	Did you breast feed?	Y N	If yes, how long? #		
Do you get routine pap smears - generally once every 3 years?	Y	N	Abnormal Pap smear?	Y	N
Do you get routine mammogram screenings?	Y	N	If yes, what age did you start? Age		
Have you ever had a breast biopsy?	Y	N	If yes, when, at what facility, and result?		

Patient Name: **Date of Birth:** **MRN:**

PREVENTIVE CARE	**YES**	**NO**	**DECLINE**
Whole Body Skin Check for Moles/Lesions for Skin Cancer - Annually	Y	N	Decline
Colonoscopy (all patients 45-80 years)	Y	N	Decline
Low Dose CT Chest for Lung Cancer Screening (ages 55 to 80 years who have a 30 pack-year smoking history (smoked one pack/day for 30 years, two packs/day for 15 years, etc.) and who currently smoke or have quit within the past 15 years.)	Y	N	Decline
PSA for Prostate Cancer Screening (men >50 years)	Y	N	Decline
Bone Density (age >60)	Y	N	Decline
Nutrition and Obesity Counseling	Y	N	Decline
Blood pressure, Diabetes, and Cholesterol tests	Y	N	Decline

IMMUNIZATIONS Please check if you have received:

☐ COVID ☐ Flu ☐ Hepatitis A ☐ Hepatitis B ☐ HPV ☐ Hib ☐ MMR ☐ Meningitis
☐ Pneumonia ☐ Zoster ☐ Tdap (Tetanus, Diphtheria, Pertussis) ☐ Varicella

HIGH RISK BEHAVIORS: ALCOHOL, TOBACCO & DRUG USE	**YES**	**NO**	**DECLINE**
Do you smoke or chew tobacco?	Y	N	Decline
In the past year, have you had: • **(MEN)** 5 or more alcohol drinks in one day? • **(WOMEN)** 4 or more alcohol drinks in one day?	Y	N	Decline
Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	Y	N	Decline

SEXUAL ISSUES	**YES**	**NO**	**DECLINE**
Do you think you or your partner could have a sexually transmitted infection (STI), such as HIV, Syphilis, Chlamydia, Gonorrhea, genital warts, etc.?	Y	N	Decline
Have you been tested for sexually transmitted infections?	Y	N	Decline
Have you or your partner(s) had sex without a condom in the past year?	Y	N	Decline
Have you been counseled on birth control?	Y	N	Decline

NEEDS ASSESSMENT	**YES**	**NO**	**DECLINE**
Transportation needs	Y	N	Decline
Food insecurity	Y	N	Decline
Housing insecurity (i.e. homelessness, safety concerns)	Y	N	Decline

MENTAL HEALTH – PHQ2 DEPRESSION SCREENING	**0 (Not at all)**	**+1 (several days)**	**+2 (more than half the days)**	**+3 (nearly every day)**
Do you feel down, depressed or hopeless?	☐	☐	☐	☐
Do you have little interest or pleasure in doing things?	☐	☐	☐	☐

NCCN DISTRESS SCREENING Please circle below the number (0-10) that best describes how much distress you have been experiencing in the past week, including today:

No Distress	0	1	2	3	4	5	6	7	8	9	10	**Extreme Distress**

FOR CLINICAL USE ONLY

Health Topic	**Counseled**	**Referred**	**Anticipatory Guidance**	**Follow-Up Ordered**	**Comments**
Physical activity	☐	☐	☐	☐	
Safety	☐	☐	☐	☐	
Alcohol, tobacco & drug use	☐	☐	☐	☐	
Sexual issues	☐	☐	☐	☐	
Needs assessment	☐	☐	☐	☐	
Mental Health	☐	☐	☐	☐	

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CONSENT FOR ACCESSING MEDICATION HISTORY ELECTRONICALLY AND EPIC CARE TO FILL PRESCRIPTION(S)

Patient Name:_____ Date Of Birth: _____

CONSENT FOR ACCESSING MEDICATION HISTORY ELECTRONICALLY

We have started to use electronic prescriptions and ask for you to grant us permission to access your medication history electronically.

Electronically accessing your medication history allows us to receive critically important information on your current and past prescriptions and to become better informed about potential medication issues. We can use this information to improve safety and quality.

By signing below I give my consent for Epic Care to access my medication history electronically.

CONSENT FOR EPIC CARE TO FILL PRESCRIPTION(S)

I acknowledge that Epic Care has offered written prescription(s) that I may choose to have filled by Epic Care or by any pharmacy of my choice.

☐ Yes, I elect to have these prescriptions filled by Epic Care with the understanding that I am under no obligation to do so.

☐ No, I do not elect to have these prescriptions filled by Epic Care.

Patient Signature or Legally Authorized Individual's Signature **Date**

Print Name **If Signed on Behalf of Patient Relationship to Patient**

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ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

We continually strive to contain costs, while maintaining our commitment to provide you the highest quality of care. The following is a statement of Epic Care's Financial Policy which requires you to read and sign prior to any treatment.

We will bill your insurance company in accordance to agreements with your insurance carrier however, you will need to provide complete billing information at the time of your visit(s) including a valid insurance card and valid personal identification. It is your responsibility to notify our office of any changes to your insurance PRIOR to services being rendered.

I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Co-Payments & Insurance Collection

We are required by law, and your health plan, to collect co-payments at the time of service. Patients are financially responsible for services provided and therefore expected to pay at the time of service. We accept Cash, Debit or any of the following credit cards: VISA, MASTER CARD, AMERICAN EXPRESS, DISCOVER and CHECK PAYABLE TO EPIC CARE.

Insurance Reimbursement & Billing

_____ I hereby give lifetime authorization for payment of insurance benefits to be made directly to Epic Care, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ I hereby authorize this healthcare provider to release any medical information necessary to process my insurance claims. I request that all payments be made on my behalf and that all benefits are assigned for physicians, service to Epic Care.

_____ I hereby authorize this request to apply to all services provided by Epic Care. I understand I am responsible for payment of any balance not paid by my insurance company. It is my responsibility to go to my insurance's authorized laboratory, hospital, and imaging facilities.

Attorney Fees and Collection Costs

If any legal action is necessary to enforce or interpret the terms of these billing policies, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which that party may entitled. You agree by your signature below to pay all collection costs, including attorneys' fee on all delinquent payments.

_____ I agree to allow Epic Care and anyone who collects or communicates on Epic Care's behalf to contact me using prerecorded or automated calls or via text message, email, or using other contact numbers or email addresses I have provided or that I obtain in the future. I agree that Epic Care will treat any contact information I provide as private and ensure that it is not accessible by unauthorized third parties. I understand that calls will be made to my cellular device during permitted calling hours based upon the time zone affiliated with the mobile telephone number I provide unless I notify Epic Care otherwise.

Patient or Legally Authorized Individual's Signature **Date**

Print Name **If Signed on Behalf of Patient, Relationship to Patient**

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CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby give my consent to release the below requested records to Epic Care.

- ☐ History & Physical
- ☐ Pathology Reports
- ☐ Radiology Reports
- ☐ Laboratory Results
- ☐ Other: _____
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Films
- ☐ Physician Notes

Patient or Legally Authorized Individual's Name and Signature

BELOW IS FOR OFFICE USE ONLY:

Date:

To:

From:

Name of Patient:

Date of Birth:

PLEASE FAX RECORDS TO THE CHECKED CENTER BELOW:

☐ **ANTIOCH Medical Oncology/Surgery** - 4721 Dallas Ranch Road • Antioch, CA 94531 **F: (925) 778-3567**

☐ **ANTIOCH Radiation Oncology** - 4721 Dallas Ranch Road • Antioch, CA 94531 **F: (925) 331-2286**

☐ **CASTRO VALLEY** - 20400 Lake Chabot Rd, Suite 102 Castro Valley, CA 94546 **F: (510) 247-9241**

☐ **DUBLIN** - 6380 Clark Avenue • Dublin, CA 94568 **F: (925) 875-0826**

☐ **EMERYVILLE** - 1480 64th Street, Suite 100 • Emeryville, CA 94608 **F: (510) 830-3316**

☐ **HAYWARD** - 27204 Calaroga Ave • Hayward, CA 94545 **F: (510) 264-9510**

☐ **PLEASANT HILL Medical Oncology** - 400 Taylor Boulevard, Suite 201 • Pleasant Hill, CA 94523 **F: (925) 687-2847**

☐ **PLEASANT HILL Radiation Oncology** - 400 Taylor Boulevard, Suite 102 • Pleasant Hill, CA 94523 **F: (925) 825-1820**

☐ **SAN LEANDRO** - 13851 E 14th Street, Suite 308 • San Leandro, CA 94578 **F: (510) 483-1856**

☐ **WALNUT CREEK** - 3003 Oak Road, Suite 104 • Walnut Creek, CA 94597 **F: (925) 391-2221**

☐ **NEW PATIENT INFORMATION DEPARTMENT** - 4721 Dallas Ranch Road • Antioch, CA 94531 **F: (925) 978-0227**

For questions, please call us at (925) 255-1066. Thank you!

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PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I _____, Date of Birth_____, MRN#_____

hereby authorize Epic Care to release the records requested below and/or the medical information within:

To:

Address:

Phone Number: Fax Number:

- ☐ History & Physical
- ☐ Pathology Reports
- ☐ Radiology Reports
- ☐ Laboratory Results
- ☐ Other: _____
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Films
- ☐ Physician Notes

OTHER RELEASE OF INFORMATION

☐ I authorize transmission of my medical information by FAX machine. (No Mental Health, AIDS-HIV or Substance abuse information will be faxed).

☐ I authorize release of information/correspondence from another facility or provider found in my medical record.

This authorization is valid for (1) one year from the date of signature. I understand that, as a patient I have the right to access my health records at any time, including during hospitalizations and after discharge. Copies of the records will be obtained with reasonable notice and payment of copying and postage cost. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original. I understand that, as a patient I have the right to revoke this authorization at any time via verbal or written request to Epic Care.

Patient or Legally Authorized Representative's Signature

Relationship to Patient (if applicable)

Record Release Date

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HIPAA NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS
To get an electronic or paper copy of your medical record and ask us to make corrections
To request confidential communications and state a preferred method of contact (home or office phone, text message, mail or email)
To ask us to limit what we use or share. We will say "yes" unless a law requires us to share that information or if it would affect your care
To get a list of those with whom we've shared information
To get a copy of this privacy notice
To choose someone to act for you
To file a complaint if you feel your rights are violated
OUR USES AND DISCLOSURES
To treat you. We may share it with other professionals who are treating you
To improve you care, manage your treatment and services.
To your health insurance plan so it will pay for the services provided to you
To contribute to public health, safety issues and health research
To comply with State and Federal Laws, including Department of Health and Human Services
To respond to organ and tissue donation requests
To collaborate with a coroner, medical examiner, or funeral director
To respond to lawsuits and legal actions (in response to a court or administrative order, or a subpoena)
OUR RESPONSIBILITIES
To maintain the privacy and security of your Protected Health Information (PHI)
To inform you promptly if a breach occurs that may have compromised the privacy or security of your information
To follow the duties and privacy practices described in this notice and give you a copy of it
To not use or share your information other than as described here unless you tell us we can in writing.

WE MAY CHANGE THE TERMS OF THIS NOTICE, AND THE CHANGES WILL APPLY TO ALL INFORMATION WE HAVE ABOUT YOU. THE NEW NOTICE WILL BE AVAILABLE UPON REQUEST, IN OUR OFFICE, AND ON OUR WEB SITE. If you have questions about this notice, please contact the HIPAA Privacy and Security Officer at hipaa@epic-care.com

BY SIGNING THIS FORM YOU ACKNOWLEDGE RECEIPT OF EPIC CARE'S NOTICE OF PRIVACY PRACTICES

First Name | Last Name | If Other Than Patient, Relationship

Signature | Date

FOR INTERNAL USE ONLY

- ☐ In-person request to obtain acknowledgment
- ☐ Request via mail
- ☐ Request via email
- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Patient did not return acknowledgment via mail, email
- ☐ Other

Epic Care Employee **FIRST** and **LAST** Name

Title

Signature | Date