



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 \_\_\_\_\_

Others\*\*:    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	<input type="checkbox"/> <b>No, I have not had or have any of the conditions listed above</b>			

**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: • <b>(MEN)</b> 5 or more alcohol drinks in one day? • <b>(WOMEN)</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol, tobacco & drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Needs assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Partners in Comprehensive Care

# 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**



Partners in Comprehensive Care

# 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 be 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.

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

**Date**

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**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 64<sup>th</sup> 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!

# 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: \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Pathology Reports  | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> Films             |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Physician Notes   |
| <input type="checkbox"/> Other: _____       |  |

## 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**

## 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](mailto: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





# NOTICE OF OPEN PAYMENTS DATABASE

## FOR INFORMATIONAL PURPOSES ONLY

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

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

**Date**

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**Print Name**

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