

New Patient History Questionnaire



Name: _____
 Primary Language: _____ Need Interpreter: YES NO
 Date of Birth: _____ Gender: _____ Ethnicity (Optional): _____
 Preferred Phone: _____ Secondary Phone: _____
 E-mail: _____ Preferred Contact: Call Text E-mail
I consent to and understand the risks of receiving protected health information via e-mail: YES NO
 Address: _____
 Emergency Contact Name: _____
 Primary Phone: _____ Relation to you: _____

MEDICAL TEAM

Referring Provider: _____ Medical Oncologist: _____
 Surgeon: _____ Primary Care: _____
 Dentist (Head & Neck only): _____ Pharmacy: _____

MEDICAL HISTORY

Current Diagnosis: _____
 Prior History of Cancer: YES NO Prior Diagnosis: _____

Prior to today, have you had any of the following outside of our facility?

Radiation: YES NO Start Date: _____ End Date: _____ Location: _____
 Chemotherapy: YES NO Start Date: _____ End Date: _____ Location: _____

Do you have any implanted medical devices: Pacemaker/Defibrillator Pain Pump Stent NONE
 When was your last colonoscopy? Date: _____ Physician: _____ Never had one
 Do you have Lupus or Scleroderma? YES NO

Answer if applicable:

Do you still want to have children? YES NO
 Are you pregnant or think you may be pregnant? YES NO

MEDICATION OR LATEX ALLERGIES (use additional space if needed)

Do you have a known allergy to IV Contrast: YES NO If yes, Reaction? _____

Allergy	Allergic Reaction	Date of Last Reaction

CURRENT SYMPTOMS – In the last 30 days have you had any of the following (check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Visual Changes |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Cough | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Swollen Lymph Nodes | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ear Pain/Ringing | <input type="checkbox"/> Bloody Stools | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Hemorrhoids |

FAMILY CANCER HISTORY (use additional space if needed)

Relative / Relation to You	Cancer Type	Age of Diagnosis

SURGERIES OR RECENT HOSPITALIZATIONS (use additional space if needed)

Type/Reason	Location/Facility	Date/Length

PAST MEDICAL HISTORY – Check All That Apply

Cognitive/Brain

- Stroke
- Seizures/Epilepsy
- Multiple Sclerosis
- Alzheimer’s/Dementia

Lung/Respiratory

- Asthma
- Pneumonia
- COPD
- Cystic Fibrosis
- Pulmonary Fibrosis

Heart/Cardiac

- Congestive Heart Failure
- Arrhythmia
- Coronary Artery Disease
- High Blood Pressure

Muscular/Skeletal

- Osteoarthritis
- Rheumatoid arthritis
- Osteoporosis
- History of Bone Fractures
- Fibromyalgia

Stomach/Intestinal/Digestive

- Diabetes Type: _____
- Ulcerative Colitis
- Crohn’s Disease
- Acid Reflux/GERD
- Constipation
- Diarrhea

Blood/Hepatic/Circulation

- Liver Disease
- Anemia
- Bruise Easily
- Hemochromatosis
- Gall Bladder Disease/Stones
- Hepatitis Type: _____
- Jaundice

Bladder/Kidney/Urologic

- Kidney Stones
- Bladder Stones
- Kidney Disease

Additional Diseases

- Ehlers-Danlos Syndrome

List any others

PAIN MANAGEMENT

Are you currently in pain? YES NO (if no, skip to next section)

On a scale of 0 – 10, what is your **average pain** level? _____

Over the last 7 days has your pain stopped you from doing daily tasks? YES NO

Do you currently see a Palliative Care Provider or Pain Specialist? YES NO

GYNECOLOGIC HISTORY (females only)

Age of Menarche: _____ Last Menstrual Period: _____ Age of Menopause if applicable: _____

History of Hormone Replacement Therapy? YES NO If yes, for how long? _____

CURRENT MEDICATIONS (If you need more space, provide current list of medications at your first visit)

Name of Medication	Dosage/Frequency	Prescriber

MENTAL HEALTH HISTORY

Do you have any of the following diagnosis? Depression Anxiety OCD Substance Use Disorder

Do you see a Mental Health Provider? YES NO

If no, are you interested in connecting with one? YES NO

SUBSTANCE USE HISTORY

Do you currently smoke cigarettes? YES NO Packs per day? _____ Age Started? _____

If no, did you smoke in the past? YES NO If yes, age you stopped? _____

Do you use cannabis? YES NO If yes, frequency: _____

Do you currently drink alcohol? YES NO If yes, do you drink daily? YES NO

If you no longer consume alcohol, what age did you stop? _____

Are you concerned about your substance use or alcohol use? YES NO

SOCIAL HISTORY

Marital Status: Married Divorced Widowed Single Partnered

Living Accommodations: Own Home Rent Unhoused ALF Other: _____

Lives with: Alone Spouse Minor Children Adult Children Family Roommates

Are you a Veteran? YES NO Service Connection/Disability %: _____

Employment Status: Employed Unemployed Retired On Leave On Disability

Do you have any of the following concerns? Employment Transportation Finances Insurance

Do you have an Oncology Navigator supporting you? YES NO Name: _____



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

USES AND DISCLOSURES

Treatment. Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of tests and procedures will be available in your medical record for all health professionals who may provide treatment or who may be consulted by our staff members.

Payment. Your health information may be used to see payment from your health insurance plan, from other sources of coverage, or from credit card companies that you may use for payment of services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Anchorage Radiation Oncology Center. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Public Health Reporting. Your information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred prior to your notification of your decision to us.

Appointment reminders. Your health information may be used by our staff to send you appointment reminders.

INDIVIDUAL RIGHTS

- You have certain rights under the federal privacy standards. These include:
- The right to request instructions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and or submit corrections to our protected health information

- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

ANCHORAGE RADIATION ONCOLOGY CENTER’S DUTIES:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy privileges and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policy and practices may be required in federal and state laws and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our front office coordinator.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to the contact person listed below.

If you believe that your privacy rights have been violated, you should call the matter to the attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated for filing a complaint.

CONTACT PERSON

The name and address of the person that you may contact for further information concerning our privacy practice is:

Privacy Officer
 Anchorage Radiation Oncology Center
 188 W Northern Lights Blvd. #100
 Anchorage, AK 99503

Your signature is an acknowledgement of receipt that you have read the Notice of Privacy Practices. If you request a copy of your notice, it will be provided.

 Printed Name of Patient/Legal Guardian

 Date

 Signature of Patient/Legal Guardian

 Relation to Patient

Patient Consent & Financial Responsibility Agreement



Name: _____ Date of Birth: _____

At **Anchorage Radiation Oncology Center**, we truly appreciate the opportunity to provide you with compassionate, state-of-the-art care. This agreement identifies your financial obligations for all the services you receive from us, including the services provided today and in the future. Please let us know if you do not understand any of the items discussed in this agreement.

Responsibility of the Patient

1. You are financially responsible for any deductible or co-insurance amounts determined by your insurance. All co-payments and/or deductibles for our services are due within 90 days of service. At your request, a financial counselor can provide you with an estimate of your financial responsibility for your treatment. However, please understand that an estimate is not binding and that the actual cost may be different. We accept payment for daily co-pays via check or credit card.
2. Please inform us of ANY and ALL insurance coverage you possess, and of any recent changes. This is crucial for proper billing and to ensure insurance coverage for our services, when available. We need correct and current information on a timely basis. If your insurance coverage changes, please contact our office immediately at 907-562-2002.
3. We will submit a claim to all insurers provided to us at the initiation of care for all applicable services and care provided. We will send you a statement reflecting the amount due after final processing from your insurance. If your account becomes delinquent, you agree to pay us for any expenses incurred on your account, including reasonable attorneys' fees and collection costs.

Financial Agreement for Integrative Services

Your medical provider may refer you to Integrative Services, these services may include palliative care, naturopathic oncology, nutrition or dietician services, acupuncture, and/or massage therapy. We will make every effort to bill your insurance provider for these services; however, please note that coverage varies by plan, and not all insurance companies reimburse for these services. If your insurance does not cover the cost, you will be responsible for the balance at our cash pay rate, which is 25% of the Medicare rate.

Initial: _____

Financial Agreement for Telehealth Services

Changes to coverage of telehealth services may have affected your insurance coverage. We will work with your insurance provider on your behalf to obtain coverage for these services but cannot guarantee these services will be covered. Effective February 1st, 2026 all telehealth services offered that are not covered by insurance will be billed at our cash pay rate of 25% of the Medicare rate.

Initial: _____

Financial Agreement for Principal Illness Navigation (PIN) Services

I understand that my serious health condition may benefit from Principal Illness Navigation (PIN) services. These services include help with coordinating my care, accessing resources, and navigating the healthcare system in alignment with the treatment plan outlined by my provider. I understand that trained staff may provide these services under the supervision of my healthcare provider. I agree to receive PIN services, and I am aware that Medicare Part B cost-sharing may apply. I know I can withdraw my consent at any time.

Initial: _____

PLEASE NOTE:

1. We are Medicare providers and accept assignments from Medicare. However, there may be a balance due from you after Medicare pays. Medicare law prohibits us from waiving this balance.
2. Carrying an outstanding balance will not prevent you from receiving continued care. If you are unable to cover an outstanding balance you may be eligible to apply for our Charity Care program, which provides financial assistance based on your needs.

By signing below, I acknowledge that I have read, understood, and agree to the financial terms outlined above.

Signature of Patient/Legal Guardian

Date

Notice of Disclosure and Release of Information



Name: _____ Date of Birth: _____

Any person/parties requesting my protected health information that is not part of my direct medical care team, facility, or organization must be noted below. The parties listed below are authorized to receive information regarding my medical care, including coordination of care, financials, and billing information unless noted otherwise.

FIRST AND LAST NAME	RELATION TO PATIENT	DOB OR PHONE #

Notes: _____

I understand that the listed above person(s) or organization receiving my protected health information will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

By signing below, I, _____, hereby authorize **Anchorage Radiation Oncology Center:** (Patient/Legal Guardian)

- To request, obtain, and receive my protected health information from healthcare providers, facility, or organization involved in my direct medical care.
- To release my protected health information to healthcare providers, facility, or organization involved in my direct medical care.
- To release my protected health information to the parties listed above, who may not be directly involved in my medical care.

This authorization expires 1 year (365 days) from the date of my signature unless otherwise noted below. If your care spans beyond 1 year you will be asked to complete a new form annually.
 Alternate date of expiration: _____

 Printed Name of Patient/Legal Guardian

 Date

Clinic Note: This authorization was revoked on: _____
 (See attached revocation)

