ST. FRANCIS CANCER CENTER
Bon Secours St. Francis Health System

Welcome!

We pledge to provide you with the best and most up-to-date care for your specific diagnosis. We believe that each patient is an individual and your case will be treated with your best interest in mind.

Your lab appointment is ___/___/___ @ _____:_____ a.m. / p.m.

Your appointment with Dr. _____ is ___/___/___ @ _____:_____ a.m. / p.m.

Please arrive at _____:_____ a.m. / p.m. to provide time for the registration process.

Location:

X Bon Secours St. Francis Cancer Center
104 Innovation Drive
Greenville, SC 29607

☐ ST.FRANCIS - Downtown
317 St. Francis Dr., Suite 340
Greenville, SC 29601

Enclosed is a questionnaire for you to complete to the best of your ability. **Please bring the completed questionnaire and all medications you are currently taking to your scheduled appointment.**

Please contact our office at any time if you have any questions or concerns (864) 603-6200. We look forward to meeting you soon.

Sincerely,

Bon Secours St. Francis Cancer Center and Hematology

Dr. R. Siegel
Dr. S. Dyar, Jr.
Dr. S. Khan
Dr. F. Quddus
Dr. X. Yang
Dr. H. Crosswell
Dr. A Grabska
Dr. D. Griffin
Dr. C. Schwab
Dr. J. Eggert
Dr. E.J. Paciarelli

PATIENT REGISTRATION AND MEDICAL HISTORY QUESTIONNAIRE

Today's Date ____/____/_____
Patient Name: _____ Gender: M ( ) F ( )
Date of Birth: ___/___/___ Age: ____ Social Security #: _____
Address: _____City: _____State: _____
Zip Code: _____ County: _____ Email: _____
Phone: Home (____) _____ Cell (____) _____ Work (____)_____

INSURANCE AND EMPLOYMENT INFORMATION

Primary Insurance: _____
Subscribers Policy # _____ Group # _____
Subscribers Name _____ Subscribers SS# _____
Subscribers DOB ___/___/___ Pt's Relationship to Subscriber _____
Secondary Insurance: _____
Subscribers Policy # _____ Group # _____
Subscribers Name _____ Subscribers SS# _____
Subscribers DOB ___/___/___ Pt's Relationship to Subscriber _____
EMPLOYER: _____ Employer Phone: _____

IN CASE OF EMERGENCY

Name of local relative or friend: _____
Relation to Patient: _____
Home Phone: _____ Alternate Phone: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Specialty: _____
Address: _____
Phone: (____) _____ Fax: (____) _____
Primary Care Physician: _____
Address: _____
Phone: (____) _____ Fax: (____) _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: (____) _____
Address: _____

HISTORY OF PRESENT ILLNESS

Please describe as briefly as possible when the symptoms of your illness started or when your present medical condition was first detected, what symptoms you had, what treatments you have had, and what the results of the treatments have been.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PREVIOUS BIOPSIES DONE *(please list earliest biopsies first)*

Approximate date of biopsy: _____ Site of biopsy: _____
Approximate date of biopsy: _____ Site of biopsy: _____
Approximate date of biopsy: _____ Site of biopsy: _____
Approximate date of biopsy: _____ Site of biopsy: _____

Have you ever had radiation therapy? _____Yes _____ No
If yes, please tell us when you started and stopped treatment, the area of your body that was treated, and the hospital or doctor who treated you.

Started Month/Year	Stopped Month/Year	Area of Body Treated	Hospital	Doctor
Did you have any particular problems with this treatment? ____ Yes ____ No If yes, please describe:				

Have you ever had chemotherapy? _____Yes _____ No				
If yes, please tell us when you started and stopped treatment and the hospital or doctor who treated you.				
Started	Stopped			
Month/Year	Month/Year	Area of Body Treated	Hospital	Doctor
Did you have any particular problems with this treatment? ____ Yes ____ No If yes, please describe:				

OTHER MEDICAL CONDITIONS (include hospitalizations)

DATE	DIAGNOSIS	TREATMENT

PAST SURGICAL HISTORY

DATE	DIAGNOSIS	TYPE OF SURGERY

Current Medications and Nutritional or other Supplements

Medication	Dose	Times per Day	Medication	Dose	Times per Day

ALLERGIES OR BAD REACTIONS TO MEDICATIONS OR INJECTED X-RAY CONTRAST

MEDICATION	TYPE OF REACTION	MEDICATION	TYPE OF REACTION

FAMILY HISTORY

Relative	If Alive		If Deceased		Other Significant Medical Problems
	Age	Health Status	Age at Death	Cause(s) of Death	
Father					
Mother					
Father's Father					
Father's Mother					
Mother's Father					
Mother's Mother					
Sibling (M__F__)					
Sibling (M__F__)					
Sibling (M__F__)					
Sibling (M__F__)					
Sibling (M__F__)					
Sibling (M__F__)					
Sibling (M__F__)					
Child (M__F__)					
Child (M__F__)					
Child (M__F__)					
Child (M__F__)					
Child (M__F__)					
Child (M__F__)					

OTHER MEDICAL CONDITIONS IN YOUR FAMILY

____ Diabetes	_____ Stroke	_____ Immune Disorder
____ High Blood Pressure	_____ Blood Clots	_____ Cancer
____ Heart Disease	_____ Easy Bruising/ Bleeding	_____ Anemia

Other (describe):

_____

_____

SOCIAL HISTORY

Family
Marital Status: _____ Married _____Widowed _____ Divorced _____ Single

Veteran Status
Do you now or have you ever served in the U.S. Armed Forces? ___Yes ___ No

Tobacco Use
Do you currently smoke cigarettes? ___Yes ___ No (If yes, ____ packs per day)
If no, did you previously smoke cigarettes? ___No ___ if yes, ___ packs per day for ____ years
If yes, when did you quit? _____
Have you used smokeless tobacco? _____ Cigars? _____ Pipe? _____

Alcohol/Drug Use
Number per week: _____ Beer _____ Glasses of Wine _____ Hard alcohol drinks
Do you believe that you drink or previously drank too much alcohol? _____Yes _____No
Do you use marijuana? _____ Other controlled substances used? _____

Possible environmental toxin exposures at home or at work
Radiation _____ Benzene _____ Toluene _____ Pesticides _____ Asbestos _____
Other potential toxin exposures: _____

Review of Systems

Current Weight: _____lbs Usual Weight: _____lbs Ht: _____feet _____inches

Weight loss in last year: _____lbs Weight gain in last year: _____lbs

Please mark all of the following symptoms that you currently have or have had within the last 6 months, unless the question begins with "History" or "Any History" or "Any Episode" which means any time in your life.

Constitutional – (No symptoms ___)

___Fever
___Drenching Sweats
___Shaking Chills
___Poor Appetite
___Sleeping Poorly at Night
___Sleeping During the Daytime
___Unusual Fatigue

Eyes – (No Symptoms ___)

___Glasses or Contact Lenses
___Substantial Change in Vision
___Loss of any area of your visual field
___Blurred Vision
___Double Vision
___Pain in eyes
___Glaucoma
___Cataracts
___Excessive Tears
___Dry Eyes
___"Pink Eye" or other eye infection

Ear, Nose & Throat – (No Symptoms ___)

___Headaches
___Sinus Infections
___Ear Infection or Earache
___Difficulty Hearing
___Ringing or Buzzing in Ears
___Vertigo (sensation of spinning around)
___Frequent Colds
___Chronic stuffy or runny nose
___Nose Bleeds
___Sore Throats
___Mouth sores
___Gums bleeding
___Hoarseness
___Frequent Throat clearing

Respiratory – (No Symptoms ___)

___Cough
___Shortness of Breath at rest
___Shortness of Breath with exertion
___Asthma and/or wheezing
___Blood in sputum
___Chest Pain
___Chest Pain – worse with deep breath

Cardiovascular – (No Symptoms ___)

___Chest pain or pressure sensation
___Chest pain or pressure with exertion
___Rapid heart beat
___Irregular (extra or skipped) heart beat
___Lightheadedness or passing out
___History of heart murmur
___Pain in legs - starts when walking
___Shortness of Breath
___Shortness of Breath with exertion
___Shortness of Breath when flat in bed
___Foot, Ankle, or Leg swelling

Gastrointestinal – (No Symptoms ___)

___Abdominal Pain
___Burning upper abdomen/mid chest pain
___Difficulty swallowing – food gets stuck
___Nausea and/or Vomiting
___Vomiting Blood
___Bloating Sensation
___Constipation
___Diarrhea (times per day _____)
___Dark Black Stools
___Blood in the Stools
___History of Hepatitis, Jaundice
___History of Cirrhosis
___Gallstones; other gall bladder problems

___History of enlarged spleen

Genitourinary (Males) –
(No Symptoms ___)
___Painful, burning, or cloudy urination
___History of urinary tract infections
___Frequent Urination
___Waking to urinate ___ times/night
___Blood in urine
___Past history of kidney stones
___Discharge from or sores on penis
___Difficulty with erection or ejaculation
___History of prostate problems
___Pain, swelling, or mass in testicles

Genitourinary (Females) –
(No Symptoms ___)
___Painful, burning, or cloudy urination
___Frequent Urination
___ Waking to urinate ___ times/night
___Blood in urine
___Past history of kidney stones
___Vaginal itching or discharge
___Vaginal bleeding (not with menstruation)
___Menopause? If so, what age? _____
___Irregular Menstrual Cycles
___Abnormal/long/heavy menstrual cycles
___History of abnormal PAP Smear
___History of 3 or more miscarriages

Breasts – (No Symptoms ___)
___Breast lumps
___Discharge or bleeding from nipples
___Pain or tenderness in breast(s)
___Date of last Mammogram _____
___History of abnormal mammogram
___Previous breast biopsy

Skin – (No Symptoms ___)
___Rash
___Itching
___Chronic or recurring skin condition
___Any past history of skin cancer

Neurologic – (No Symptoms ___)
___Memory loss or forgetfulness
___Frequent of severe headaches
___Fainting, near fainting, or dizziness
___History of serious head injury
___History of seizures/epilepsy
___History of stroke
___History of (mini-stroke) TIA
___Any areas of numbness or tingling
___Any areas of loss of pain sensation
___Any areas of chronic pain or burning
___Unsteadiness standing or walking
___Tremor
___Weakness of any leg or arm
___Any episode of garbled speech
___Any episode of loss of vision

Psychiatric – (No Symptoms ___)
___Depression – Medication
___Overly Anxious – Medication
___History of any psychiatric problem
___Any psychiatric hospitalizations

Hematological – (No Symptoms ___)
___Enlarged lymph nodes (glands)
___History of bleeding disorder
___History of Blood Clots
___Easy Bruising
___Excessive bleeding after being cut
___History of anemia
___History of low white blood cells
___History of low platelet counts

Allergy/Immunology –
(No Symptoms ___)
___Inhalant allergy (grass, weed, mold)
___Allergies to any food
___Autoimmune (Rheumatiod, Lupus, others)
___Frequent infections
___History of shingles

Musculoskeletal – (No Symptoms ___)

___Arthritis, joint pain or swelling
___Back pain or tenderness
___Any other bone pain
___Muscle pain or tenderness
___History of gout or high uric acid level

Endocrine – (No Symptoms ___)

___Diabetes
___Thyroid disease or goiter
___Pituitary or adrenal gland disease
___Parathyroid disease; high or low blood calcium level

Please list any questions you would like your physicians to answer during today's appointment:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Gynecology Oncology

Dr. David Griffin and Dr. Carlton Schwab

For gynecology patients only

Patient Name: _____ Patient Age: _____

Today's Date: _____

In order to give you the best medical care, it is necessary to be thorough and complete. Your entire medical history and present complaint will be reviewed with you. You will also have a complete physical examination and additional tests and scans may be ordered if indicated. We would like for you to fill out the following questionnaire completely and accurately. You will have an opportunity to discuss in detail any part of this history and any medical problems that you may have. You will also be able to ask any questions that may be troubling you.

THIS IS PART OF YOUR MEDICAL RECORD AND IS ABSOLUTELY CONFIDENTIAL

Please check each question that applies to you and put (?) if uncertain.

MAIN REASON FOR VISIT:

_____

_____

_____

Height _____ Weight _____ Average Weight _____

OBSTETRICAL HISTORY:

How many pregnancies have you had? _____ Number of live vaginal births ____ C-Sec _____

Number of tubal pregnancies _____ Miscarriages _____ Abortions _____

GYNECOLOGIC HISTORY:

Age of first period: _____ First day of last menstrual period: _____

If not menstruating, stopped at what age: _____

Due to menopause: ( ) Yes ( ) No Due to hysterectomy? ( ) Yes ( ) No

Reason for hysterectomy: _____

Have you had any bleeding or spotting? ( ) Yes ( ) No

Have you missed any periods without being pregnant? ( ) Yes ( ) No

Are your periods: ( ) Regular ( ) Somewhat irregular ( ) Very irregular

Interval between first day of one period to first day of next period ranges from _____ to _____ days

Menstrual flow usually lasts for a total of _____ days. Menstrual flow usually is ( ) Scant ( ) moderate ( ) heavy ( ) excessive with clots

Date of last pap smear: _____ Was it normal/abnormal? _____

Please circle Yes or No

Are your periods usually painful? ……yes or no

Do you have bleeding or spotting between periods or after intercourse? ……. ….yes or no

Do you have any abdominal/pelvic pain unrelated to menstruation? ……...yes or no

Do you have pain with intercourse? ……..yes or no

Do you have vaginal irritation, discharge or dryness? ……yes or no

Do you have itching, irritation, sores or lumps around your vulva or vagina? …….. …….yes or no

Do you frequently have sudden urges to urinate? ……..yes or no

Do you have night urination, dribbling urine, or bedwetting? …… yes or no

Do you ever have a protrusion or bulging sensation from your vagina? …….yes or no

Have you ever had an abnormal pap smear? …….yes or no

CURRENT CONTRACEPTION:

Birth control pills: _____ Diaphram: _____ IUD: _____ Condoms: _____

Tubal: _____ Other: _____ None: _____

Are you currently sexually active: ( ) yes ( ) no

SURGERY:

	Year		Year		Year		Year
Gallbladder	_____	Heart	_____	Cervix	_____	Appendix	_____
Tumor	_____	Ovary	_____	Kidney	_____	Hernia	_____
Uterus	_____	Tonsils	_____	Vagina	_____	Thyroid	_____
Chest/Lung	_____	C-Sec	_____	Breast	_____	Spine	_____

D&C _____ Bowel _____ Vulva _____ Tubal Ligation _____

Hemorrhoids _____

Have you ever been advised to have any surgical procedure which has not been done? _____

(If, yes, please explain)

_____

_____

Infectious Disease: Check any of the following that you've had:

( ) Abscess: describe: _____
( ) Rheumatic Fever
( ) TB
( ) Herpes: last outbreak _____
( ) Hepatitis: Type: _____
( ) Bladder/Kidney
( ) Sexually Transmitted Disease
( ) Tubal Infection
( ) HIV/AIDS
( ) Pneumonia

Medical Problems: (Please circle all that apply)

Convulsions	Stomach ulcer
Varicose veins	Emphysema
High blood pressure	Bone disease
Hernia	Bronchitis
Hemorrhoids	Colitis/Irritable bowel

Migraines: How often: _____

Date of last mammogram and results: _____

Date of last colonoscopy and results: _____

Doctors who treat you for the above illnesses (cardiologist, pulmonologist, family doctor, etc.)

	#1	#2	#3
Specialty	_____	_____	_____
Name	_____	_____	_____
Phone	_____	_____	_____

Have you ever had a blood transfusion? ( ) yes ( ) no
X-rays or Scans done in the past year?

_____

****

THANK YOU FOR YOUR TIME AND WE LOOK FORWARD TO SERVING YOU

FINANCIAL POLICY

Thank you for choosing Bon Secours Hematology & Oncology as your healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our Billing and Financial Department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our Financial Policy as well as complete the Patient Information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, American Express, VISA, MasterCard and Discover. As a courtesy to you, it is the policy of Bon Secours Hematology & Oncology to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

PLEASE INITIAL THE FOLLOWING:

_____ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

_____ 2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees. Patients without insurance are advised to meet with the Financial Coordinator prior to their first visit (or prior to therapy change) to provide financial information for review of possible available assistance or drug replacement programs.

_____ 3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Bon Secours Hematology & Oncology, you recognize an obligation to promptly remit payment to Bon Secours Hematology & Oncology.

_____ 4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Bon Secours Hematology & Oncology, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

_____ 5. I understand if my outstanding balance becomes greater than the acceptable age (60-90 days). I will be asked to ask for an agreement for settling the previous balance and require either a deposit on the current visit or payment in full. I may also be asked to sign a promissory note if the practice deems appropriate.

_____ 6. Labs that are offered in our practice can be expensive and should be discussed with your provider prior to having the specimen sent to the lab. I understand if cost is a concern, a price list can be referred in our lab area.

At Bon Secours Hematology & Oncology, we understand that financial problems may affect timely payment; we encourage you to communicate any such problem to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call our Billing Department at (864)603-6310.

I UNDERSAND THE ABOVE INFORMATION AND WILL BE RESPONSBILE FOR THE PATIENT LISTED BELOW.

Printed Name of Patient:_____ Account:_____

_____ _____

Signature of Patient or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attached please find Bon Secours Hematology & Oncology Notice of Privacy Practices. Your name and signature on this cover sheet indicate that you have received a copy of Bon Secours Hematology & Oncology Notice of Privacy Practices on the date indicated. This notice is yours to keep. If you have any questions regarding the information set forth in our Notice of Privacy Practices, please do not hesitate to contact our Office Manager, Kristen Hames at (864) 603-6300.

Printed Name of Patient:_____

Signature:_____ Date:_____

Authority to Sign, if not Patient:_____

Request for authorization for disclosure of Protected Health Information (PHI) to family member(s), friend(s), and/or caregiver(s) authorized to review PHI:

Name	Relationship

Patient Signature:_____

***Patient DOB: _____/_____/_____ Mother's Maiden Name: _____

*** If the person(s) authorized above calls for access to your PHI, they will have to give the above identifiers in order to have access to the information over the phone. This includes billing information. Picture ID will be requested if requesting access in person.

Bon Secours St. Francis Cancer Center
104 Innovation Drive
Greenville, South Carolina 29607
Phone 864-603-6331 | Fax 864-603-6161

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Release Information From:
__Bon Secours St Francis Cancer Center
__Other: _____ _____
Facility/Physician/Pharmacy to release information from — Fax Number

_____
Address — City — State — Zip Code

Disclose/Release Information To:
_x_ Bon Secours St Francis Cancer Center
___ Other: _____ _864-603-6161___
Facility/Physician/Pharmacy to release information from — Fax Number

104 Innovation Drive **Greenville** **SC** **29607**
Address — City — State — Zip Code

Purpose of Disclosure:

☐ Continued Care

☐ Personal (I understand that I may be charged for copies of this information in accordance with SC law.)

☐ Other: Please send lab results, pathology results, imaging results, consult notes, treatment notes, and OV notes – thank you

Patient Name:	Patient SS Number: xxx-xx-
Patient Address:	Patient Date of Birth:
City/State/Zip Code:	Patient's Phone Number:

I understand that the information indicated above, which may include information regarding alcohol and/or drug abuse, mental illness, HIV testing and diagnosis and treatment considered confidential and is to be utilized by the recipient only for the above purpose.

_____
Signature of Patient — Relationship (if not patient) — Date

_____
Witness — Date

PLEASE FAX RECORDS-DO NOT MAIL