

**WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER  
PATIENT DEMOGRAPHICS**



**PLEASE COMPLETE THE ENTIRE FORM**

<b>Patient Information</b>			
Today's Date:		Date of Birth:	
Social Security Number:			
Legal Last Name:	Legal First Name:	Middle Name:	Preferred Name:
Referring Physician:		Referring Physician Phone Number:	
Primary Care Physician:		Primary Care Physician Phone Number:	
<b>Patient Contact Information</b>			
Home Address (Street, City, State, Zip):			
Mailing Address (Street, City, State, Zip):			
<input type="checkbox"/> Same as the home address			
Phone:		Alternate Phone:	
Is this a cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this a cell phone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email Address:		Preferred Contact Method:	
		<input type="checkbox"/> Phone <input type="checkbox"/> Alternate Phone <input type="checkbox"/> Email <input type="checkbox"/> Patient Portal	
<b>Patient Demographics</b>			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Choose not to disclose			
Preferred Pronouns:	Gender Identity:	Sexual Orientation:	Sex (Assigned at Birth):
<input type="checkbox"/> She, Her, Hers	<input type="checkbox"/> Female	<input type="checkbox"/> Straight or Heterosexual	<input type="checkbox"/> Female
<input type="checkbox"/> He, Him, His	<input type="checkbox"/> Male	<input type="checkbox"/> Lesbian, Gay, Homosexual	<input type="checkbox"/> Male
<input type="checkbox"/> They, them, theirs	<input type="checkbox"/> Transgender Male (FTM)	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other, please describe _____	<input type="checkbox"/> Transgender Female (MTF)	<input type="checkbox"/> Other, please describe _____	
<input type="checkbox"/> Choose not to disclose	<input type="checkbox"/> Genderqueer/Non-binary	<input type="checkbox"/> Unknown	
	<input type="checkbox"/> Other, please describe _____	<input type="checkbox"/> Choose not to disclose	
	<input type="checkbox"/> Choose not to disclose		
Race:		Ethnicity:	
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> Asian		<input type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Unknown	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Other, please specify _____	
<input type="checkbox"/> White		<input type="checkbox"/> Choose not to disclose	
<input type="checkbox"/> Other Race, please specify _____			
<input type="checkbox"/> Choose not to disclose			
Preferred Language:	Preferred Language for Written Documents:	Do you need a medical interpreter at appointments at no cost?	
		<input type="checkbox"/> Yes, specify language _____	
		<input type="checkbox"/> No	
Occupation and Employer:		Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed	
		<input type="checkbox"/> Retired <input type="checkbox"/> Student (Full) <input type="checkbox"/> Student (Part)	
		<input type="checkbox"/> Choose not to disclose	

STAFF USE ONLY

RECEIVING STAFF INITIALS: \_\_\_\_\_ PATIENT MRN: \_\_\_\_\_

COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK

AUGUST 2023 VERSION 1.2

WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER  
ONCOLOGY ASSOCIATES OF OREGON  
ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES



**PLEASE COMPLETE THE ENTIRE FORM**

Patient Information			
Legal Last Name:	Legal First Name:	Middle Initial:	Date of Birth:
Billing Address (Street, City, State, Zip):			
Primary Insurance Information			
Company:	Subscriber Name:	Subscriber Date of Birth:	
Group Number:		ID/Policy Number:	
Secondary Insurance Information			
Company:	Subscriber Name:	Subscriber Date of Birth:	
Group Number:		ID/Policy Number:	
Tertiary Insurance Information			
Company:	Subscriber Name:	Subscriber Date of Birth:	
Group Number:		ID/Policy Number:	
Assignment of Benefits, Authorization to Release Medical Information:			
<p>I request that payment of authorized benefits from my insurance carrier be made either to me or on my behalf to Willamette Valley Cancer Institute and Research Center and Oncology Associates of Oregon (collectively "WVCI") for any services furnished to me by WVCI, and I hereby assign to WVCI all assignable rights to payment for services rendered by WVCI, including all Medicare benefits if I am in that program. I authorize my insurance carrier to release information regarding my coverage to WVCI. I authorize any holder of medical information about me to release it to the following when applicable to determine benefits for related services: Division of Family Services, Centers for Medicare and Medicaid Services, insurers and/or agents of these companies, or other healthcare providers assisting in my medical care. I understand and agree that my health information may be used and disclosed by WVCI, other providers, and insurers for treatment, payment and health care operations purposes.</p> <p>I understand that in order for WVCI to comply with the federally mandated initiative for electronic medication prescribing (e prescribing) software to send prescriptions over the internet to pharmacies, these transmissions are done in a safe manner that protects the privacy of personal information. I agree that WVCI may request and use my prescription history from other healthcare providers or third-party payors for treatment purposes as required by the above-mentioned federal initiative. I authorize WVCI to obtain my prescription history.</p>			
<p><b>FINANCIAL AGREEMENT:</b></p> <p>I understand that I am financially responsible for any charges regardless of insurance coverage. Should I default, I agree to pay all cost of collections including interest applied by collection agency, court cost and attorney fees. Any suit filed may be brought in the county where services are rendered.</p> <p>I have read and agree to the provisions on this form and accept the terms. A duplicate of this form is considered the same as original.</p>			
<b>THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING</b>			
Patient Signature:			Relationship to Patient:
(for patients 17 years of age or younger, parent or guardian MUST sign)			
Printed Name:		Date:	

STAFF USE ONLY

RECEIVING STAFF INITIALS: \_\_\_\_\_ PATIENT MRN: \_\_\_\_\_

COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK

AUGUST 2023 VERSION 1.1

WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER  
ONCOLOGY ASSOCIATES OF OREGON  
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT



Willamette Valley Cancer Institute and Research Center (WVCI) has a responsibility to protect the privacy of your health care information. WVCI also has a responsibility to give a Notice of Privacy Practices that describes:

- how your health care information may be used and shared
- how you can get your health care information
- whom to reach if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time. You may call WVCI at **541-683-5001** to get an up-to-date copy of the notice or to ask questions. **This form will be retained in your records.**

**By my signature below, I agree that I have received the Notice of Privacy Practices of Willamette Valley Cancer Institute and Research Center.**

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Printed Patient Legal Name – First, Middle, Last

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Signature of Patient or Patient's Personal Representative

Date

Time

*If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:*

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Name of Personal Representative

Relationship to Patient

Phone Number

FOR INTERNAL USE ONLY
<i>If acknowledgment was not obtained, please state the reason:</i>
PRINTED WVCI EMPLOYEE NAME
SIGNATURE OF WVCI EMPLOYEE

STAFF USE ONLY

RECEIVING STAFF INITIALS: \_\_\_\_\_ PATIENT MRN: \_\_\_\_\_

COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK

AUGUST 2023 VERSION 1.1

## User Electronic Mail Authorization Form

### Patient Portal: Ontada Health®

Ontada Health®, 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.

Because personal identifying information and other 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 choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Ontada Health® Portal. **Please look for an email from Ontada Health® promptly after submitting this form.**

For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

#### Terms

You are receiving access to the Ontada Health® Portal the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

\_\_\_\_\_  
Patient Name  
(First Name, Middle Initial, Last Name)

\_\_\_\_\_  
Email Address of Patient/Authorized User

\_\_\_\_\_  
Date of Birth of Patient

\_\_\_\_\_  
Physician's Name

Authorized User is:

- ☐ Patient  
☐ Patient's Designee

\_\_\_\_\_  
Patient's Designee's Name (Printed)

\_\_\_\_\_  
Patient's Designee's Signature

\_\_\_\_\_  
Patient's Medical Record Number

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Practice Staff  
[confirming user's identity and authority]

\_\_\_\_\_  
Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Patient's Designated User) understands and agrees to use the listed email address for this purpose. Please make a copy for patient

#### STAFF USE ONLY

RECEIVING STAFF INITIALS: \_\_\_\_\_

PATIENT MRN: \_\_\_\_\_

COMMITTEES\FORMS\ADMINISTRATIVE FORMS\FRONT DESK

☐ PATIENT DECLINED PORTAL ACCESS

☐ EMAIL IN PMS OR IKM

SEPTEMBER 2023 VERSION 1.1

3<sup>rd</sup> PARTY ACCESS ☐ NO ☐ YES



## PATIENT CONSENT FOR PRACTICE TO COMMUNICATE WITH OTHERS

Patient Legal Name (First, Middle Initial, Last)

Date of Birth

Phone Number (Home/Cell)

Phone Number (Work)

### 1. Alternate Contact Information Authorization

WVCI has my authorization to:	Leave medical information on my home/cell voice mail	Y	N
	Contact me at my place of employment	Y	N
	Leave medical information on voice mail at my place of employment	Y	N

### 2. Family / Friends Release of Information Authorization

I authorize WVCI to speak with, and verbally disclose my health information to, the following person(s) regarding my medical care and treatment and payment for those services.

**Please note: This form supersedes the information provided on previous forms.**

Name	Relationship to Patient	Phone Number	Y	N
			Emergency Contact?	
Name	Relationship to Patient	Phone Number	Y	N
			Emergency Contact?	
Name	Relationship to Patient	Phone Number	Y	N
			Emergency Contact?	
Name	Relationship to Patient	Phone Number	Y	N
			Emergency Contact?	
Name	Relationship to Patient	Phone Number	Y	N
			Emergency Contact?	
Name	Relationship to Patient	Phone Number	Y	N
			Emergency Contact?	

### 3. Validation and Signature

*I understand that I can change this list at any time by notifying WVCI in writing. Written revisions will not affect any action taken in reliance on this consent before the written notice was received.*

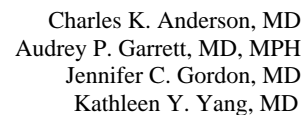
Signature of Patient

Date

**\*If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:**

Name of Personal Representative

Relationship to Patient



Date _____			
<div style="display: flex; justify-content: space-between;"> <span>Print Last Name</span> <span>First Name</span> <span>Middle Name</span> </div>			
<div style="display: flex; justify-content: space-between;"> <span>Age</span> <span>Date Of Birth</span> <span>Occupation</span> </div>			
<div style="display: flex; justify-content: space-between;"> <span>Address</span> <span>City</span> <span>State</span> <span>Zip</span> </div>			

Main reason for visit:
Years of School _____

**Medical History:** Have you ever had or do you have now any problems with the following: Please Circle

Anemia	Asthma/Bronchitis	Blood Clots	Blood Disorders	High Cholesterol
Diabetes	Eating disorders	Epilepsy/fainting	Emphysema	Gall Bladder Disease
Gonorrhea	Headaches	Heart Disease	Hemorrhoids	Hepatitis
Herpes	Hearing/Vision Problems	High Blood Pressure	Kidney Disease	Liver Disease
Lung Disease	Mental Health Problems	Ovarian Cyst or tumor	Pelvic Infections	Pneumonia
Rheumatic Fever	Stomach Ulcers	Stroke	Thyroid Problems	Uterine Growth Colon Cancer

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical History:** List operations you have had and the reason for surgery. Please give approximate year and list in chronological order, if possible, including tonsils, D&C, C-Sections, etc.

#1	
#2	
#3	
#4	
#5	
#6	

Have you had a blood transfusion? \_\_\_\_\_

**History of any serious medical problems? Have you ever been hospitalized?**

**Medications:** Please list any medicines (prescriptions or over-the-counter) you take:

<u>Medicine</u>	<u>Amount</u>	<u>How often taken</u>	<u>Medicine</u>	<u>Amount</u>	<u>How often taken</u>



Charles K. Anderson, MD  
Audrey P. Garrett, MD, MPH  
Jennifer C. Gordon, MD  
Kathleen Y. Yang, MD

PRINT First Name \_\_\_\_\_ Last Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

**Allergies:** Please list medication and what reaction you had:

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**Family History:** Has any member of your family, including parents, grandparents, brothers, or sisters ever had: (list person or persons involved):

Cancer: Person	How old were they when they had the disease	did this person die of the disease
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Breast Cancer:	_____	_____
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Colon Cancer:	_____	_____
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Ovarian Cancer:	_____	_____
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Uterine Cancer:	_____	_____
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Other Cancer:	_____	_____
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Diabetes _____	Heart disease _____
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High blood pressure _____	Kidney disease _____
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Lung disease _____	Blood clots _____
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Excessive bleeding (with dental extractions, child birth etc.) \_\_\_\_\_

**Breasts:**

Have you ever had a mammogram? \_\_\_\_\_ Date of last mammogram \_\_\_\_\_

Have you had a breast biopsy? \_\_\_\_\_

**Colon:**

Have you ever had a colonoscopy? \_\_\_\_\_ Date of last colonoscopy / result \_\_\_\_\_

**Bone Density:**

Have you had bone density screening? \_\_\_\_\_ Date: \_\_\_\_\_

**Menstrual History:**

What was the first day of your last normal menstrual period? \_\_\_\_\_

At what age did your menstrual periods begin? \_\_\_\_\_ How long are your usual menstrual cycles? (28-30 days apart?) \_\_\_\_\_

What is an average number of days you flow? \_\_\_\_\_ Any Cramps? \_\_\_\_\_ Is the flow heavy? \_\_\_\_\_

Date of your last PAP smear? \_\_\_\_\_ Have you ever had an abnormal PAP smear? \_\_\_\_\_ When? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Age of Menopause, if applicable \_\_\_\_\_ Symptoms? \_\_\_\_\_

**Birth Control History** (if applicable):

Present method \_\_\_\_\_ last Used? \_\_\_\_\_

Problems with present or prior methods \_\_\_\_\_

**Pregnancy History:**

Number of: Pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Living Children \_\_\_\_\_ Miscarriages \_\_\_\_\_ Therapeutic Abortions \_\_\_\_\_

How old is your youngest child? \_\_\_\_\_ Birth weight: Largest \_\_\_\_\_ Smallest \_\_\_\_\_ Age at first pregnancy \_\_\_\_\_

What problems did you have with prior pregnancies, births or abortions? \_\_\_\_\_

**Social History:** Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_

What drugs have you used (marijuana, amphetamines, cocaine?) \_\_\_\_\_

Have you ever shared needles? \_\_\_\_\_

On a scale of 1 – 10 (1=very poor; 10=excellent) how would you rate: your job / work situation? \_\_\_\_\_ Home? \_\_\_\_\_

If applicable, how would you rate your relationship with your spouse / partner? \_\_\_\_\_

Have you ever had problems with your sex life? \_\_\_\_\_

Have you ever been hurt by sex? \_\_\_\_\_

Have you ever been forced to have a sexual encounter? \_\_\_\_\_

What is your height? \_\_\_\_\_ Recent weight? \_\_\_\_\_ Desired weight? \_\_\_\_\_

Are there any special concerns you would like to discuss with the doctor during your visit?

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Thank You! The Medical History Form will go directly to your physician.

## Review of Symptoms

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please review and mark any current symptoms or problems you have experienced in the last six months.

### General:

- ☐ Loss of appetite
- ☐ Fever/chills
- ☐ Night sweats
- ☐ Weakness
- ☐ Fatigue

### Hematologic:

- ☐ Abnormal bleeding
- ☐ Abnormal bruising
- ☐ Swollen glands

### Allergies/immunologic:

- ☐ Seasonal allergies
- ☐ Food allergy \_\_\_\_\_
- ☐ Sinus Problems
- ☐ Frequent infections

### Skin:

- ☐ Slow healing
- ☐ Rash
- ☐ Nail change
- ☐ Change in skin or mole
- ☐ Other \_\_\_\_\_

### Breasts:

- ☐ Discharge/bleeding
- ☐ Lump
- ☐ Pain

### Eyes:

- ☐ Change in vision
- ☐ Eye infection
- ☐ Eye pain

### Ears/Nose/Throat:

- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Neck swelling/lumps
- ☐ Nose bleeds
- ☐ Dental Issues

### Cardiovascular:

- ☐ Chest discomfort/pain
- ☐ Irregular heart beat
- ☐ Swollen hands or feet
- ☐ Racing heart

### Respiratory:

- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Cough up blood
- ☐ Difficulty breathing

### Gastrointestinal:

- ☐ Bloody or black stools
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Heartburn/esophageal reflux
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Pain with bowel movements
- ☐ Jaundice

### Urinary:

- ☐ Blood in urine
- ☐ Frequency
- ☐ Difficulty urinating
- ☐ Pain or burning with urination
- ☐ Incontinence

### Musculoskeletal:

- ☐ Back or neck pain
- ☐ Painful or stiff joints
- ☐ Bone pain, Site: \_\_\_\_\_
- ☐ Arthritis

### Mental Health:

- ☐ Depressed or sad
- ☐ Anxiety
- ☐ Sleep issues
- ☐ Suicidal thoughts

### Neurological:

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of balance
- ☐ Difficulty speaking
- ☐ Loss of sensation
- ☐ Memory Issues
- ☐ Seizures

### Endocrine:

- ☐ Weight loss
- ☐ Weight gain
- ☐ Excessive thirst
- ☐ Heat/cold intolerance

### FOR WOMEN

#### Gynecological:

- ☐ Irregular menstrual periods
- ☐ Hot flashes
- ☐ Menopause
- ☐ Heavy menstrual bleeding