WILLAMETTE VALLEY CANCER INSTITUTE AND RESEARCH CENTER
PATIENT DEMOGRAPHICS

PLEASE COMPLETE THE ENTIRE FORM

Patient Information

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:	

Patient Contact Information

Home Address (Street, City, State, Zip):

Mailing Address (Street, City, State, Zip):
☐ Same as the home address

Phone: Is this a cell phone? ☐ Yes ☐ No	Alternate Phone: Is this a cell phone? ☐ Yes ☐No
Email Address:	Preferred Contact Method: ☐ Phone ☐ Alternate Phone ☐ Email ☐ Patient Portal

Patient Demographics

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Choose not to disclose

Preferred Pronouns: ☐ She, Her, Hers ☐ He, Him, His ☐ They, them, theirs ☐ Other, please describe _____ ☐ Choose not to disclose	Gender Identity: ☐ Female ☐ Male ☐ Transgender Male (FTM) ☐ Transgender Female (MTF) ☐ Genderqueer/Non-binary ☐ Other, please describe _____ ☐ Choose not to disclose	Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay, Homosexual ☐ Bisexual ☐ Other, please describe _____ ☐ Unknown ☐ Choose not to disclose	Sex (Assigned at Birth): ☐ Female ☐ Male ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race, please specify _____ ☐ Choose not to disclose	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other, please specify _____ ☐ Choose not to disclose

Preferred Language:	Preferred Language for Written Documents:	Do you need a medical interpreter at appointments at no cost? ☐ Yes, specify language _____ ☐ No
Occupation and Employer:	Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐Student (Full) ☐ Student (Part) ☐ Choose not to disclose	

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:

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.

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 provides or third-party payors for treatment purposes as required by the above-mentioned federal initiative. I authorize WVCI to obtain my prescription history.

FINANCIAL AGREEMENT:
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.

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.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

Patient Signature: (for patients 17 years of age or younger, parent or guardian MUST sign)	Relationship to Patient:
Printed Name:	Date:

STAFF USE ONLY
RECEIVING STAFF INITIALS: _____ PATIENT MRN: _____

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.

Printed Patient Legal Name – First, Middle, Last

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:

Name of Personal Representative Relationship to Patient Phone Number

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

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

3rd 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	✓	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	Emergency Contact?
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N

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***

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

MEDICAL HISTORY FOR GYNECOLOGICAL CARE

Date_____

Print Last Name First Name Middle Name

Age Date Of Birth Occupation

Address City State Zip

Main reason for visit:

Years of School_____

Partner's Name_____ Age_____ Occupation _____
Who is your Primary Care Physician? _____

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:

Medicine	**Amount**	**How often taken**	**Medicine**	**Amount**	**How often taken**

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:

_____

_____

_____

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

Breast Cancer: _____

Colon Cancer: _____

Ovarian Cancer: _____

Uterine Cancer: _____

Other Cancer: _____

Diabetes _____ Heart disease _____

High blood pressure _____ Kidney disease _____

Lung disease _____ Blood clots _____

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?

_____

_____

_____

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

Check this box if you do ***NOT* have any symptoms listed:**

☐I do **not** have any symptoms.

Reviewed/Approved, OCM Quality Committee, May 2017, updated 2/12/2026