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:

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***

Medical History Form

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Personal Medical History: Have you ever been diagnosed with the following? (Please check)

- ☐ **Cancer**
- ☐ **Heart Disease/CHF**
- ☐ High Blood Pressure
- ☐ **Blood Disorders**
- ☐ **Anemia**
- ☐ **Blood Clots**
- ☐ Neurological disease
- ☐ **Epilepsy/seizures**
- ☐ **Stroke**
- ☐ Migraines
- ☐ **Lung Disease**
- ☐ **Pneumonia**
- ☐ Asthma
- ☐ Asbestos Exposure
- ☐ Tuberculosis
- ☐ **Emphysema/COPD**
- ☐ **Liver Disease**
- ☐ **Hepatitis**
- ☐ **Pancreatic disease**
- ☐ Inflammatory Bowel Disease
- ☐ Gallbladder disease
- ☐ **Kidney Disease**
- ☐ Thyroid Problems
- ☐ **Diabetes**
- ☐ **Alcohol/Drug dependence**
- ☐ **Mental Health Issues**
- ☐ **Rheumatoid Arthritis**
- ☐ **Lupus/autoimmune**
- ☐ **Multiple Sclerosis**
- ☐ **HIV/AIDS**
- ☐ Osteoarthritis
- ☐ **Skin ulcers**

Other: _____

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

1. _____
2. _____
3. _____
4. _____

Hospitalizations, Serious illness, and injuries: Please give approximate date and list in chronological order if possible.

1. _____
2. _____
3. _____
4. _____

Have you had a blood transfusion? ☐Yes ☐No

Family History:

Relationship	Please circle	Age	If Deceased: Age at Death and Cause of Death	Significant Medical History
Father	Alive Deceased			
Mother	Alive Deceased			
Sibling 1:	Alive Deceased			
Sibling 2:	Alive Deceased			
Sibling 3:	Alive Deceased			
Sibling 4:	Alive Deceased			

Has any of your extended family ever had any of the following (including cousins, grandparents, aunts/uncles):

Relationship	Maternal or Paternal	Age at Onset	History of Cancer (If yes, indicate type)	History of blood clots (If yes, where)	History of excessive bleeding (if yes, where)
Grandmother					
Grandfather					
Grandmother					
Grandfather					
Aunt/Uncle					
Aunt/Uncle					
Cousin					

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Do you have an advance directive for healthcare decisions? ☐Yes ☐No

Social History:

Do you use nicotine? ☐Yes ☐No How much/how long: _____ Quit/When: _____
What type? ☐Cigarettes ☐Cigars ☐Chew
Do you drink alcohol? ☐Yes ☐No How much/how long: _____ Quit/When: _____
Have you used drugs? ☐Yes ☐No What type: _____Quit/When: _____
Marital Status: ☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐Widowed
Living Situation: ☐ Alone ☐Roommate ☐Spouse/Partner ☐Significant Other ☐With Children ☐Parents

Immunizations: Please give date of most recent vaccination or series completion date.

Influenza: _____Pneumonia: _____ Hepatitis A: _____ Hepatitis B: _____
Shingles: _____ Tetanus: _____ HPV: _____ Meningococcal: _____

Preventative Health:

Have you ever had a colonoscopy? ☐Yes ☐No
Date/location of last colonoscopy: _____Findings:_____
Have you ever had bone density test? ☐Yes ☐No
Date/location of last test: _____ Findings: _____
Have you had a mammogram? ☐Yes ☐No
Date/location of last mammogram: _____Findings:_____

FOR WOMEN

Menstrual History:

Date of last period: _____ Age periods began: _____ Age of Menopause: _____
Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? ☐Yes ☐No
Number of live births: _____ Number of pregnancies: _____
Current birth control method: _____ Are you interested in preserving your fertility? ☐Yes ☐No

Medication Allergies: List medication and reaction.

Medication	Reaction	Medication	Reaction

Medication List: List medication, dose and how often you take it. Include non-prescriptive items and supplements.

Name	Dose	Frequency	Name	Dose	Frequency

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

New Patient Breast Questionnaire

Name: _____ **DOB:** _____

1. Age of first period: _____ years old
2. Menopausal? ☐ Yes ☐ No
3. Age of first live birth? _____ years old ☐ N/A
4. Number of children: _____
5. Did you breastfeed? ☐ Yes ☐ No
6. History of Oral Contraceptive use? ☐ Previous ☐ Current ☐ Never
7. History of Hormone Replacement Therapy? ☐ Previous ☐ Current ☐ Never
8. Do you have your ovaries? ☐ Both Intact ☐ 1 Removed: L / R ☐ Both Removed
9. Any nipple discharge? ☐ Yes – if yes, color/consistency: _____ ☐ No
10. Number of breast biopsies: _____ (Left: _____ Right: _____)
11. History of trauma to the breasts? ☐ Yes – explain: _____ ☐ No
12. Have any relatives tested positive for genetic mutations?

☐ Yes explain: _____ ☐ No

13. Family History of Breast Cancer?

☐ Yes - explain: _____ ☐ No

14. If yes to question 13 and a first-degree relative (mom, sibling, child) had breast cancer at what age were they diagnosed? _____
15. Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No ☐ Decline to Respond

Ambient and Remote Scribe Technology

Your provider uses a secure and HIPAA-compliant technology that may use ambient and remote scribe tools. These tools will create your electronic medical records in real-time or non-real time and assist your provider throughout your visit. The audio stream or recording is stored securely in accordance with HIPAA guidelines and used for better medical care delivery, improved medical documentation, and quality assurance. The audio stream or recording will not be retained on a permanent basis. The audio stream or recording will not be used outside routine treatment and operations.

I have been informed that it is my choice if I want to use ambient and remote scribe technologies in my visit with my provider. I also realize that by signing this form, I give my consent to allow the provider to use this technology in all my future visits. I have had all my questions answered by the provider or staff member.

If at any time I decide not to allow this technology, I am to let the staff or provider know, and the provider will not use it.

I understand the above, and consent to the use of ambient and remote scribe technology in my appointments. This consent is valid from the date I sign, for all future visits. At any point in time, it is my right to decline the use of ambient and remote scribe technology.

_____ _____

Patient name (please print) Date of Birth

_____ _____

Signature of patient or legally authorized representative Date