

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):							
<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			
Patient Demographics							
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 provides 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> 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> <p align="center"><b>THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING</b></p>			
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: \_\_\_\_\_

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
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*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
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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**

**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)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Alcohol/Drug dependence |
| <input type="checkbox"/> Heart Disease/CHF    | <input type="checkbox"/> Migraines         | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Mental Health Issues    |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Lung Disease      | <input type="checkbox"/> Pancreatic disease         | <input type="checkbox"/> Rheumatoid Arthritis    |
| <input type="checkbox"/> Blood Disorders      | <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Lupus/autoimmune        |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Gallbladder disease        | <input type="checkbox"/> Multiple Sclerosis      |
| <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Asbestos Exposure | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Thyroid Problems           | <input type="checkbox"/> Osteoarthritis          |
| <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Emphysema/COPD    | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> 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.



## 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