

My dear patient,



I want you to know how much I appreciate your careful attention to completing ALL of these forms.

I know it seems like a lot of paperwork, but each question covers an important aspect of your health and may influence the decision about the best type of treatment for you.

When you help me to fully understand your situation, together, we become a powerful team for your health.

Thank you in advance!

Dr Holmes



Patient Registration Form

Patient Information					
Patient's Last Name		First Name		Middle	
Gender ○Male ○Female	Date of Birth	Social Security #	Age	Phone Number	
Address			City	State	Zip Code
Occupation		Employer		Work Phone	
Business Address			City	State	Zip Code
Relative/Friend Not Living With You			Relationship	Telephone	
Address			City	State	Zip Code
Marital Status ○Single ○Married ○Divorced ○Widowed		Spouse's Name		Date of Birth	
Spouse's Occupation		Employer		Work Phone	
Business Address			City	State	Zip Code
How did you hear about us?					
Referring Physician				Phone Number	
Primary Care Physician				Phone Number	
Insurance Information					
Primary Insurance or Medicare			Policy Number	Group Number	
Name of Insured			Preauthorization Required <input type="checkbox"/>	Date of Birth	
Secondary Insurance or Medicare			Policy Number	Group Number	
Name of Insured			Preauthorization Required <input type="checkbox"/>	Date of Birth	
I request that payment of authorized benefits (from the above listed insurance companies) be made on my behalf to: Texas Oncology for any services furnished me by my physician(s). I authorize the holder of medical information about me to release to the Health Care Financing Administration or the above listed insurance companies information needed to determine these benefits payable for related services.					
In lieu of a physical signature my name, the date, and my confidential PIN will certify this document.					
Patient or Responsible Party Name			Relationship	Date	PIN

New Patient Medical History Questionnaire

Last Name	First Name	Your Date of Birth																							
What is the reason you came here?	How can I best help you?	MD NOTES																							
<p>Briefly, tell me the IMPORTANT EVENTS IN YOUR HISTORY OF BREAST CANCER. Example: Aug '02 Felt Lump</p>		<p>Dear Patient: If you need more space, you may write in the MD NOTES column.</p> <p style="text-align: right;">☺ <i>Thanks!</i></p>																							
<input type="checkbox"/> Reach To Recovery? <input type="checkbox"/> Arm Motion? <input type="checkbox"/> Persistent Pain?																									
<p>Tell me about your BACKGROUND BREAST HISTORY:</p> <p style="text-align: center;">Reproductive History</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Age at 1st menstrual period</td> <td style="width: 33%;">Date of last period</td> <td style="width: 34%;">Are your periods regular? <input type="radio"/> No <input type="radio"/> Yes</td> </tr> <tr> <td>Have you entered menopause? <input type="radio"/> No <input type="radio"/> Yes</td> <td colspan="2">When was your last pelvic exam?</td> </tr> <tr> <td>How many Pregnancies</td> <td colspan="2">Live Births</td> </tr> <tr> <td>Miscarriages</td> <td colspan="2">Abortions</td> </tr> <tr> <td>Age at 1st Pregnancy</td> <td colspan="2">Age at Last Pregnancy</td> </tr> <tr> <td>Did you breastfeed? <input type="radio"/> No <input type="radio"/> Yes</td> <td colspan="3">How long (weeks) for each baby?</td> </tr> <tr> <td>#1</td> <td>#2</td> <td>#3</td> <td>#4</td> </tr> </table>			Age at 1 st menstrual period	Date of last period	Are your periods regular? <input type="radio"/> No <input type="radio"/> Yes	Have you entered menopause? <input type="radio"/> No <input type="radio"/> Yes	When was your last pelvic exam?		How many Pregnancies	Live Births		Miscarriages	Abortions		Age at 1 st Pregnancy	Age at Last Pregnancy		Did you breastfeed? <input type="radio"/> No <input type="radio"/> Yes	How long (weeks) for each baby?			#1	#2	#3	#4
Age at 1 st menstrual period	Date of last period		Are your periods regular? <input type="radio"/> No <input type="radio"/> Yes																						
Have you entered menopause? <input type="radio"/> No <input type="radio"/> Yes	When was your last pelvic exam?																								
How many Pregnancies	Live Births																								
Miscarriages	Abortions																								
Age at 1 st Pregnancy	Age at Last Pregnancy																								
Did you breastfeed? <input type="radio"/> No <input type="radio"/> Yes	How long (weeks) for each baby?																								
#1	#2	#3	#4																						
Children																									
Name	Age	Where (s)he lives	Healthy?																						

			MD NOTES
Birth Control and Plans for Future Children			
Are you sexually active? <input type="radio"/> No <input type="radio"/> Yes			
Do you use birth control? <input type="radio"/> No <input type="radio"/> Yes (pls check method):			
<input type="radio"/> Rhythm <input type="radio"/> Condom <input type="radio"/> Other (pls list) _____ <input type="radio"/> Birth Control Pills <input type="radio"/> Diaphragm or Sponge			
Did you ever use Birth Control Pills? <input type="radio"/> No <input type="radio"/> Yes If Yes, How long? _____			
When did you stop? _____			
When did you start? <input type="radio"/> Before your 1 st pregnancy <input type="radio"/> After first 1 st pregnancy			
Did you use any other hormones? <input type="radio"/> No <input type="radio"/> Yes		Names	
How Long		Reason	
Do you hope to have children in the future? <input type="radio"/> No <input type="radio"/> Yes		If yes... Do you wish to see a fertility specialist to discuss egg/embryo preservation? <input type="radio"/> No <input type="radio"/> Yes	
Any previous breast problems? <input type="radio"/> No <input type="radio"/> Yes		Bra Size	
Previous breast surgeries or biopsies? <input type="radio"/> No <input type="radio"/> Yes		Date	Which Breast <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Both
Results			
Anyone in family with breast or ovarian cancer? <input type="radio"/> No <input type="radio"/> Yes		Anyone in Family with any other type of cancer? <input type="radio"/> No <input type="radio"/> Yes	
If yes to either of the last two questions please list type of cancer, their relation to you, age at diagnosis, if breast cancer was it in one or two breasts, and if they died from it.			
Family Origin (Knowing your family roots helps me determine if you may have a genetic cause) <input type="checkbox"/> Askenazi Jewish <input type="checkbox"/> Dutch <input type="checkbox"/> Icelandic <input type="checkbox"/> None of these			
Radiation to your chest or neck before the diagnosis? <input type="radio"/> No <input type="radio"/> Yes		Date	Part of Body

Medical Problems				MD NOTES
<input type="radio"/> None <input type="radio"/> See list below				
List problem, age at diagnosis, and treatment				
Example:	<i>blood pressure</i>	<i>51</i>	<i>Norvasc pills</i>	
	Problem	Age	Treatment	
1.				
	Problem	Age	Treatment	
2.				
	Problem	Age	Treatment	
3.				
	Problem	Age	Treatment	
4.				
	Problem	Age	Treatment	
5.				
Your Surgeries or Hospitalizations				
<input type="radio"/> None <input type="radio"/> See list below				
1.	Date	Surgeries or Hospitalization	Reason / Result	
2.	Date	Surgeries or Hospitalization	Reason / Result	
3.	Date	Surgeries or Hospitalization	Reason / Result	
4.	Date	Surgeries or Hospitalization	Reason / Result	
5.	Date	Surgeries or Hospitalization	Reason / Result	

Allergies			MD NOTES
Allergies to Medicines <input type="radio"/> None <input type="radio"/> See list below			
1. Medication	Reaction	Age when reacted	
2. Medication	Reaction	Age when reacted	
3. Medication	Reaction	Age when reacted	
4. Medication	Reaction	Age when reacted	
5. Medication	Reaction	Age when reacted	
6. Medication	Reaction	Age when reacted	
7. Medication	Reaction	Age when reacted	
8. Medication	Reaction	Age when reacted	
9. Medication	Reaction	Age when reacted	
10. Medication	Reaction	Age when reacted	
Seasonal Allergies <input type="checkbox"/> Pollen <input type="checkbox"/> Mold <input type="checkbox"/> Other <input type="checkbox"/> None			
Food Allergies <input type="radio"/> None <input type="radio"/> See list below (shrimp, peanuts, tomatoes, strawberries, chocolate?)			
1. Food	Reaction	When last reacted	
2. Food	Reaction	When last reacted	
3. Food	Reaction	When last reacted	
4. Food	Reaction	When last reacted	
5. Food	Reaction	When last reacted	
6. Food	Reaction	When last reacted	
7. Food	Reaction	When last reacted	
8. Food	Reaction	When last reacted	
9. Food	Reaction	When last reacted	
10. Food	Reaction	When last reacted	
Skin Allergies <input type="checkbox"/> Tape <input type="checkbox"/> Latex <input type="checkbox"/> Other (please list) <input type="checkbox"/> None			
Skin Allergy List			

Medications					
Pharmacy Name		Location		Phone	Fax
1.	Medicine	Dose	How Often	Reason	Doctor
2.	Medicine	Dose	How Often	Reason	Doctor
3.	Medicine	Dose	How Often	Reason	Doctor
4.	Medicine	Dose	How Often	Reason	Doctor
5.	Medicine	Dose	How Often	Reason	Doctor
6.	Medicine	Dose	How Often	Reason	Doctor
7.	Medicine	Dose	How Often	Reason	Doctor
8.	Medicine	Dose	How Often	Reason	Doctor
Over-The-Counter Medications					
<input type="radio"/> None <input type="radio"/> See list below					
1.	Medicine	Dose	How Often	Reason	
2.	Medicine	Dose	How Often	Reason	
3.	Medicine	Dose	How Often	Reason	
4.	Medicine	Dose	How Often	Reason	
5.	Medicine	Dose	How Often	Reason	
Vitamins / Minerals					
<input type="radio"/> None <input type="radio"/> See list below					
1.	Medicine	Dose	How Often	Reason	
2.	Medicine	Dose	How Often	Reason	
3.	Medicine	Dose	How Often	Reason	
4.	Medicine	Dose	How Often	Reason	
5.	Medicine	Dose	How Often	Reason	
Herbs / Natural Remedies					
<input type="radio"/> None <input type="radio"/> See list below					
1.	Medicine	Dose	How Often	Reason	
2.	Medicine	Dose	How Often	Reason	
3.	Medicine	Dose	How Often	Reason	
4.	Medicine	Dose	How Often	Reason	

Family History					MD NOTES
○ None, I'm adopted ○ See list below					<div style="border: 1px solid black; padding: 5px;"> Please help me learn about your genes by filling out this as completely as possible... especially any history of cancers. ☺ <i>Thanks!</i> </div>
Relation Father	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Father's Dad	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Father's Mom	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Father' Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Father' Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Father' Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Mother	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Mother's Dad	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Mother's Mom	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Mother's Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Mother's Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Mother's Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Your Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Your Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Relation Your Bro/Sis	<input type="radio"/> Alive <input type="radio"/> Dead	Sex	Age	Health Problems	
Social History					
Where were you born?		If not born in Texas, why did you come here?		Years in Texas	
Highest grade level	Degrees or certifications? <input type="radio"/> No <input type="radio"/> Yes	Degree	Degree		
Your Occupation		Your Spouse's Occupation			
Your Religion		Will you accept a blood transfusion, if needed? <input type="radio"/> No <input type="radio"/> Yes			
Companionship <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Significant other				How Long?	
Who lives at home with you?		Who is your emotional support, the one you talk to?			
Do you have advance directives?		<input type="radio"/> No <input type="radio"/> Yes			
Do you have a durable power of attorney? If Yes...		<input type="radio"/> No <input type="radio"/> Yes			
Name of choice # 1		Name of choice # 2			

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<p align="center">Mobility Requirements at Home</p> <p><input type="radio"/> 1st floor, no stairs <input type="radio"/> Stairs only to bedroom <input type="radio"/> Must walk at least 1 flight of stairs</p>			MD NOTES
<p align="center">Ability to walk</p> <p><input type="radio"/> Walk without help <input type="radio"/> Need cane <input type="radio"/> Walker <input type="radio"/> Wheel chair <input type="radio"/> Other support</p>			
Personal Habits			
<p>Have you ever smoked? <input type="radio"/> No <input type="radio"/> Yes</p>	<p>Packs per day</p>	<p>How many years?</p>	
<p>Have you ever tried to quit? <input type="radio"/> No <input type="radio"/> Yes</p>	<p>Date</p>	<p>Are you still smoking? <input type="radio"/> No <input type="radio"/> Yes</p>	<p>Packs per day</p>
<p>Do you drink alcohol? <input type="radio"/> No <input type="radio"/> Yes</p>	<p align="center">Type</p> <p><input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Mixed drinks</p>		<p>How Often? <input type="radio"/> Daily <input type="radio"/> Weekly</p>
<p>Do you drink caffeine? <input type="radio"/> No <input type="radio"/> Yes</p>	<p align="center">Amount</p>		
<p>Have you used any illegal drugs? <input type="radio"/> No <input type="radio"/> Yes</p>		<p align="center">Drugs used & when</p>	
<p>Regular Exercise? <input type="radio"/> No <input type="radio"/> Yes</p>	<p align="center">Describe</p>		<p align="center">How Often?</p>
<p>Hobbies? <input type="radio"/> No <input type="radio"/> Yes</p>	<p align="center">Describe</p>		
Vaccinations & Immunizations (if applicable and note year received)			
<p><input type="checkbox"/> Flu Year</p>	<p><input type="checkbox"/> Pneumonia Year</p>	<p><input type="checkbox"/> Hepatitis Year</p>	
<p><input type="checkbox"/> Tetanus Year</p>	<p><input type="checkbox"/> Shingles Year</p>	<p><input type="checkbox"/> Other Year</p>	
<p>If 50 or older or if colon cancer runs in your family...</p>			<p><input type="checkbox"/> Colonoscopy Year</p>
Appliances or Artificial Parts			
<input type="radio"/> None <input type="radio"/> Check below			
<input type="checkbox"/> Upper Dentures	<input type="checkbox"/> Lower Dentures	<input type="checkbox"/> Dental Implants	<input type="checkbox"/> Dental Bridges
<input type="checkbox"/> Artificial Hip	<input type="checkbox"/> Artificial Knee	<input type="checkbox"/> Artificial Elbow	
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Implanted Catheter Port	
<input type="checkbox"/> Breast Implants	<input type="checkbox"/> Contact Lenses		
General Health			
Do you feel healthy? <input type="radio"/> Yes <input type="radio"/> No			
Activity Level			
<p><input type="radio"/> 100% normal</p> <p><input type="radio"/> 90% do everything but have to "push myself"</p> <p><input type="radio"/> 80% do "almost" everything</p> <p><input type="radio"/> 70% walking ok, but can't work; out of bed or char at least half day</p> <p><input type="radio"/> 60% walk ok but tire easily; out of bed or chair at least half day; take care of personal needs</p> <p><input type="radio"/> 50% in bed or char half the day; can't do some self care</p> <p><input type="radio"/> 40% in bed or chair half the day; very little self care</p> <p><input type="radio"/> 30% bed or wheel char confined; no self care</p>			
<p align="center">Pain</p> <p><input type="radio"/> None <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe</p>		<p align="center">Nausea on a scale of 0 ☺ to 10 ☹</p> <p>(0: none; 10: vomiting)</p>	
<p align="center">Pain level on a scale of 0 ☺ to 10 ☹</p> <p>(10: having a baby or a kidney stone)</p>		<p align="center">Depression on a scale of 0 ☺ to 10 ☹</p> <p>(0: none; 10: severe)</p>	

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Weight <input type="radio"/> No change in last 1 year <input type="radio"/> Gain <input type="radio"/> Loss How many lbs in last year?	MD NOTES	
<input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Hot flashes <input type="checkbox"/> None		
Head <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Injury to head <input type="checkbox"/> Surgery <input type="checkbox"/> No problems or no change		
Eyes <input type="checkbox"/> Vision problems <input type="checkbox"/> Glasses <input type="checkbox"/> Cataracts <input type="checkbox"/> Lens implants <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Glaucoma <input type="checkbox"/> Bifocals <input type="checkbox"/> Contact lenses <input type="checkbox"/> Red or itchy from allergies <input type="checkbox"/> No problems or no change		
Ear Problems <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Hearing Aids: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Inner ear (balance) problems <input type="checkbox"/> Infections <input type="checkbox"/> None		
Nose <input type="checkbox"/> Runny <input type="checkbox"/> Itchy <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Polyps <input type="checkbox"/> Hard to breath through one side <input type="checkbox"/> No problems or no change		
Throat <input type="checkbox"/> Phlegm <input type="checkbox"/> How often: <input type="checkbox"/> What color: <input type="checkbox"/> Tonsils removed <input type="checkbox"/> Hoarseness <input type="checkbox"/> Cough <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Mouth ulcers <input type="checkbox"/> No problems or no change		
Teeth Problems <input type="checkbox"/> Toothache <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> TMJ <input type="checkbox"/> None		Last Dental Visit
Neck <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Cold when everyone else is hot <input type="checkbox"/> Goiter <input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Hot when everyone else is cold <input type="checkbox"/> Knots <input type="checkbox"/> Lumps <input type="checkbox"/> No problems or no change		
Lungs <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Short of breath on exertion Date of last chest x-ray: <input type="checkbox"/> No problems or no change		
Heart <input type="checkbox"/> Click <input type="checkbox"/> Pacemaker <input type="checkbox"/> Faint/blackout <input type="checkbox"/> Heart attack <input type="checkbox"/> Murmurs <input type="checkbox"/> EKG abnormal <input type="checkbox"/> Ankle/leg swells <input type="checkbox"/> Valve problems Heart rhythm: <input type="checkbox"/> Too fast <input type="checkbox"/> Too slow <input type="checkbox"/> Irregular <input type="checkbox"/> Chest pain (angina) spreads to <input type="checkbox"/> Jaw <input type="checkbox"/> Neck <input type="checkbox"/> Arm <input type="checkbox"/> No problems or no change		
Blood Vessels <input type="checkbox"/> Catheter <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Catheter problems <input type="checkbox"/> Blood clot <input type="checkbox"/> Legs <input type="checkbox"/> Lung <input type="checkbox"/> No veins <input type="checkbox"/> Varicose veins <input type="checkbox"/> Fingers / toes cold <input type="checkbox"/> Turn blue <input type="checkbox"/> Turn white <input type="checkbox"/> Painful <input type="checkbox"/> No problems or no change		
Blood <input type="checkbox"/> Bleed <input type="checkbox"/> Bruise <input type="checkbox"/> Anemia <input type="checkbox"/> Low blood counts <input type="checkbox"/> No problems or no change		
Urine <input type="checkbox"/> Repeat infections <input type="checkbox"/> Change in color <input type="checkbox"/> Blood in urine <input type="checkbox"/> Can't control <input type="checkbox"/> Feel urge to pass urine without result <input type="checkbox"/> Kidney stones <input type="checkbox"/> Burns / hurts <input type="checkbox"/> Wear adult diaper or pad to protect clothing <input type="checkbox"/> No problems or no change <input type="checkbox"/> Have to get up at night		

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Assignment of Benefits and Financial Responsibilities

Patient Information				
Last Name	First Name	Middle	Age	
Home Phone	Cell Phone	Work Phone		
Home Address	City	State	Zip Code	
Mailing Address	City	State	Zip Code	
Email Address				
Gender <input type="radio"/> Male <input type="radio"/> Female		Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Significant Other		
Home Health / Hospice Name				
<i>The Texas Cancer Incident Reporting Act requires cancer incidence reporting to the Texas Cancer Registry (TCR) mandatory. Primary racial origin captures information used in research and cancer control activities.</i>				
Race				
<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Chamorran	<input type="checkbox"/> Asian/Indian/Pakistani/Sri Lankan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Fiji Islander	<input type="checkbox"/> Filipino	<input type="checkbox"/> Guananian NOS	<input type="checkbox"/> Kampuchean/Cambodian
<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Hmong	<input type="checkbox"/> Japanese	<input type="checkbox"/> Korean	<input type="checkbox"/> Melanesian NOS
<input type="checkbox"/> Laotian	<input type="checkbox"/> Micronesian NOS	<input type="checkbox"/> New Guinean	<input type="checkbox"/> Polynesian NOS	<input type="checkbox"/> Pacific Islander NOS
<input type="checkbox"/> Samoan	<input type="checkbox"/> Native American	<input type="checkbox"/> Tahitian	<input type="checkbox"/> Thai	<input type="checkbox"/> Tongan
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other Asian including Asian NOS and Oriental NOS			<input type="checkbox"/> Other
Employer	Address	City	State	Zip Code
Responsible Party Name		Relationship	Telephone	
Emergency Contact / Spouse / Next of Kin Name		Relationship	Telephone	
Alternate Emergency Contact Name		Relationship	Telephone	
Referring Physician		Primary Care Physician		
Insurance Information				
Primary Insurance	Telephone	Policy Number	Group Number	
Subscriber Name	Date of Birth	Employer		
Secondary Insurance	Telephone	Policy Number	Group Number	
Subscriber Name	Date of Birth	Employer		
Tertiary Insurance	Telephone	Policy Number	Group Number	
Subscriber Name	Date of Birth	Employer		
1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection, and legal action (if required). 2. I authorize my insurance carrier to release information regarding my coverage to Texas Oncology P.A. 3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Texas Oncology P.A. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Texas Oncology P.A. 4. I understand that I have the right to request and receive a Notice of Privacy Practices from Texas Oncology P.A. 5. Notice to Patients: By submitting your check for payment, you are authorizing Texas Oncology, PA, or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.				
THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.				
I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. In lieu of a physical signature my name, the date, and my confidential PIN will certify this document.				
Patient or Responsible Party Name		Relationship	Date	PIN



Consent / Authorization for Release of Information

1. I hereby authorize:			
Name	Phone	Fax	
Address	City	State	Zip Code
To release the following information from the health records of:			
Patient's Last Name	First Name	Middle	
Phone Number	Covering the period(s) of treatment:	From	To
2. Information to be released:			
<input type="checkbox"/> Progress Note <input type="checkbox"/> Radiology <input type="checkbox"/> Lab <input type="checkbox"/> Billing Records <input type="checkbox"/> X-Ray Films <input type="checkbox"/> Web based access to Electronic Health Records <input type="checkbox"/> Complete Medical Record (includes information regarding insurance, demographic, referral documents and records.)		<input type="checkbox"/> Mail Copies <input type="checkbox"/> Patient Pickup <input type="checkbox"/> Faxed <input type="checkbox"/> Web-Email	
3. Information is to be released to:			
Name		Phone	Fax
Dr. Frankie Ann Holmes, Texas Oncology		713-467-1722	713-343-0324
Address	City	State	Zip Code
909 Frostwood #221	Houston	Texas	77024-2305
4. For the purpose of:			
<input type="radio"/> Treatment <input type="radio"/> Payment <input type="radio"/> Health Care Operations <input type="radio"/> Other _____			
5. Revocation:			
I understand that I may revoke this consent/authorization at any time by notifying Texas Oncology® in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.			
6. Authorization:			
This authorization will remain in effect until revoked by me in writing.			
7. Liability:			
The facility, its employees and officers, and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.			
8. Applicable Laws:			
I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.			
_____		_____	
Patient Signature		Date/Time	AM or PM (circle one)
_____		_____	
Responsible Party Signature	Relationship	Date/Time	AM or PM (circle one)

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Acknowledgement Of Receipt Of Notice Of Privacy Practices

<p>Texas Oncology is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have read our Notice of Privacy Practices.</p>	
<p>I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Oncology.</p>	
Last Name	First Name
Name of Personal Representative (if appropriate)	
Last Name	First Name
Date Signed	
Texas Oncology Use only	
Date acknowledgement received	
Or reason acknowledgement was not received.	

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