VENTURA COUNTY
RADIATION
ONCOLOGY
MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

PERSONAL HISTORY AND PATIENT QUESTIONNAIRE

New Patient ☐ Returning Patient ☐

NAME: _____ DOB: _____ AGE: _____ DATE: _____

Welcome to Ventura County Radiation Oncology Medical Group (VCROMG).

Please provide us with a list of your physician team followed by a few questions specific to our office.

PHYSICIAN TEAM

Physician Name:	Phone No:
Primary Care: _____	_____
Medical Oncologist: _____	_____
Surgeon: _____	_____
Other: _____	_____
Other: _____	_____
Other: _____	_____

RADIATION THERAPY HISTORY:

Have you had prior radiation therapy? Yes ☐ No ☐ If yes, what part of the body was treated_____

Location of Facility/Treating Physician _____

Has a family member or friend ever been treated by Dr. O'Connor or Dr. Montes? Yes ☐ No ☐

If yes, please list their name(s):_____

CARDIAC DEVICE:

Do you have a pacemaker or ICD (defibrillator)? Yes ☐ No ☐ If yes, date last checked_____

Please bring your cardiac device card with you to your appointment.

ADVANCE DIRECTIVE:

Do you have an Advance Directive? Durable Power of Attorney ☐
Living Will ☐ or DNR ☐

Name of person assigned_____

Phone number_____

VENTURA COUNTY RADIATION ONCOLOGY MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

NAME:_____ DOB: _____

CURRENT MEDICATIONS AND ALLERGIES: If you are unable to fill this section out PLEASE bring your medications with you to your appointment!

___ **See Attached List**

Medication Name:	# of milligrams:	How many times a day?

Are you currently taking Multi-Vitamins or Anti-Oxidants?: Please list them:

_____ _____

_____ _____

PREVIOUS CHEMOTHERAPY? Yes ☐ No ☐ PRESENT OR PLANNED TREATMENTS IN FUTURE? Yes ☐ No ☐

If YES: Name of Drug: _____ Date of Last Treatment: _____

DRUG, FOOD OR LATEX ALLERGY:

☐ None

☐ List what you are allergic to: Type of reaction:

_____ _____

_____ _____

PHARMACY:

NAME:_____ ADDRESS:_____ PH#_____

CONSENT FOR E-PRESCRIBING & OBTAINING MEDICATION HISTORY

I understand that as a part of my electronic health record, VCROMG will transmit my prescriptions electronically as permitted, to the pharmacy that I designate as my primary pharmacy provider. Additionally, VCROMG will obtain the history of my prescriptions from pharmacy benefit managers and I understand that those prescriptions will become a part of my electronic health record. By signing below I hereby give consent to the above actions.

SIGNATURE_____ DATE_____

VENTURA COUNTY RADIATION ONCOLOGY MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

NAME:_____ DOB: _____

☐ If you are a returning patient and your Medical/Family/Social History has not changed since your last visit please check here and skip to page 5 (last page).

MEDICAL HISTORY: Please mark any you have now or have had in the past.

☐ **No previous medical or surgical history**

☐ Anemia
☐ Asthma
☐ Atrial Fibrillation
☐ Bleeding disorder
☐ Blood clots
☐ Cancer (Type)_____
☐ Chronic lung disease (COPD)
☐ Cirrhosis of liver
☐ Colon polyps
☐ Congestive Heart Failure
☐ Connective tissue disease (e.g. scleroderma)
☐ Crohn's disease
☐ Diabetes
☐ Diverticulitis
☐ Emphysema
☐ Enlarged prostate
☐ Frequent Urinary Tract infections
☐ Gallstones
☐ Glaucoma/cataracts
☐ Hearing loss (R/L)
☐ Heart attack-MI
☐ Heartburn/Reflux
☐ Heart murmur
☐ Hepatitis A/B/C
☐ High blood pressure
☐ High Cholesterol/Triglycerides
☐ HIV/AIDS
☐ Irregular Heart Beat
☐ Irritable Bowel Syndrome
☐ Kidney stones
☐ Kidney Disease/Failure
☐ Autoimmune
☐ Migraines
☐ Neuropathy
☐ MRSA
☐ Osteoarthritis
☐ Osteoporosis
☐ Pancreatitis
☐ Paralysis (area)_____
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Pneumonia/ Bronchitis
☐ Reynaud's Syndrome
☐ Rheumatic fever
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sleep Apnea
☐ Stomach ulcer
☐ Stroke
☐ TB (Tuberculosis)
☐ Thyroid Disease
☐ TMJ
☐ Ulcerative colitis

Other Illnesses Not Listed: _____

Have you had a colonoscopy? Yes ☐ No ☐ and if so when _____

SURGICAL HISTORY:

Type:	Date:	Complications:

VENTURA COUNTY RADIATION ONCOLOGY MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

NAME:_____ DOB: _____

GYNECOLOGICAL-FOR WOMEN ONLY:

Age at first menstruation _____
Frequency of cycle (every so many days) _____
Date of last menses _____
Possibility you are or may be pregnant? Yes ☐ No ☐
Age at first pregnancy _____
Number of pregnancies _____

Number of live births _____
Breast fed? Yes ☐ No ☐
Age at start of menopause _____
Have you used estrogen supplementation? Yes ☐ No ☐
Recent mammogram _____ Date _____
Recent bone density scan _____ Date _____

FAMILY HISTORY OF CANCER:

Yes ☐ No ☐ If yes:

Family Member	Cancer Type	If alive, Age	If deceased, Age and cause

SOCIAL HISTORY:

Occupation: _____ Retired Yes ☐ No ☐

Family/Friend support person: _____

Do you live alone, with spouse or with another family member? Please specify: _____

Do you or have you ever smoked cigarettes? Yes ☐ No ☐
Other tobacco products? Yes ☐ No ☐

Current everyday smoker? How much?_____

Former smoker? How much?_____ Date quit_____

Do you drink alcohol? Yes ☐ No ☐ How Much?_____

Do you have a history of illicit drug use? Yes ☐ No ☐ If yes, approximately when:_____

VENTURA COUNTY RADIATION ONCOLOGY MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

REVIEW OF SYSTEMS:

Do you currently have? (If yes, check appropriate boxes)

☐ **Check here if no current symptoms** **Height** _____ **Weight** _____

EYES
☐ Double Vision
☐ Eye Pain

ENMT
☐ Decrease Hearing
☐ Hearing Aids
☐ Ear Pain
☐ Nose Bleeds
☐ Dry Mouth
☐ Hoarseness
☐ Oral Ulcers
☐ Sore Throat

CARDIOVASCULAR
☐ Chest Pain
☐ Leg Pains with Walking
☐ Leg Swelling
☐ Palpitations
☐ Shortness of Breath

RESPIRATORY
☐ Decreased Exercise Tolerance
☐ Difficulty Breathing
☐ Coughing Up Blood
☐ Sputum Production

GASTROINTESTINAL
☐ Abdominal Pain
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Vomiting
☐ Trouble Swallowing
☐ Rectal Bleeding

GENITOURINARY
☐ Painful Urination
☐ Increase Frequency
☐ Lack of Bladder Control
☐ Blood in Urine
☐ Vaginal Discharge
☐ Menstrual Irregularities

MUSCULOSKELETAL
☐ Muscle Weakness
☐ Muscle Aches/Pains

INTEGUMENTARY (SKIN/BREAST)
☐ New skin lesion
☐ Rash
☐ Breast Mass
☐ Breast Pain
☐ Nipple Discharge

NEUROLOGIC
☐ Dizziness/Vertigo
☐ Headaches
☐ Numbness/Tingling

PSYCHIATRIC
☐ Anxiety
☐ Depression

ENDOCRINE
☐ Increased Sweating
☐ Hair Changes

HEMATOLOGY
☐ Easy Bruising
☐ Enlarged Lymph Nodes
☐ Prolonged Bleeding
☐ Anemia

CONSTITIONAL
☐ Fatigue
☐ Weight Gain > 10 pounds
☐ Weight Gain < 10 pounds
☐ Poor Appetite
☐ Diet Restrictions
☐ Pain Scale 0-10_____
Location_____

IMMUNIZATION HISTORY:

Have you received a Influenza (flu) vaccine? Yes ☐ Date_____
No ☐ Personal reasons_____ Medical reasons_____

Have you received Pneumonia vaccine? Yes ☐ Date_____
No ☐ Personal reasons_____ Medical reasons_____

Print Name: _____ Patient Signature: _____ Date: _____

VENTURA COUNTY RADIATION ONCOLOGY MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

REVISION DE SISTEMAS:

¿Tiene usted actualmente? (Si la respuesta es sí, marque las casillas apropiadas)

☐ **Marque aquí si no hay síntomas actuales** **Estatura** _____ **Peso** _____

OJOS
☐ Doble Vision
☐ Dolor de ojo

ENMT
☐ Disminución de la audición
☐ Audifonos
☐ Dolor de oido
☐ Sangrado de la nariz
☐ Boca seca
☐ Ronquera
☐ Las úlceras orales
☐ Dolor de garanta

CARDIOVASCULAR
☐ Dolor de pecho
☐ Los dolores en las piernas al caminar
☐ Hinchazón de las piernas
☐ Palpitaciones
☐ Falta de aliento

RESPIRATORIO
☐ Disminución del ejercicio
☐ Respiración dificultosa
☐ Tosiendo sangre
☐ Producción de esputo

GASTROINTESTINAL
☐ Dolor abdominal
☐ Estreñimiento
☐ Diarrea
☐ Nauseas
☐ Vómitos
☐ Dificultad al tragar
☐ Sangrado rectal

GENITOURINARIAS
☐ Dolor al orinar
☐ Aumento de frecuencia
☐ La falta de control de la vejiga
☐ Flujo vaginal
☐ Irregularidades menstruales
☐ Sangre en la orina

MUSCULOESQUELÉTICO
☐ Debilidad muscular
☐ Dolores musculares/Dolores

INTEGUMENTARIO (PIEL/MAMA)
☐ Lesión de la piel nueva
☐ Erupción
☐ Masa de mama
☐ Dolor en los senos
☐ Secreción del pezón
☐ Cambios en la piel

NEUROLOGICO
☐ Perdida del control intestinal
☐ Mareos/vértigo
☐ Dolor de cabeza
☐ Entumecimiento/Hormigueo

PSIQUIÁTRICO
☐ Ansiedad
☐ Depressión

ENDOCRINO
☐ Aumento de sudor
☐ Aumento de micción
☐ Cambios en el cabello

HEMATOLGIA
☐ Moretone con facilidad
☐ Linfático agrandado
☐ Sangrado prolongado
☐ Anemia

CONSTITUCIONAL
☐ Fatiga
☐ El aumento de peso > 10 libras
☐ La perdida de peso < 10 libras
☐ Poco apetito
☐ Restricciones de dieta
☐ Escala de dolor 0-10_____
Ubicación_____

HISTORIAL DE VACUNACIÓN:

¿Ha recibido una vacuna contra la influenza (gripe)?
Sí ☐ Fecha_____
No ☐ Por razones personales_____ Por razones médicas_____

¿Ha recibido la vacuna contra la neumonía?
Sí ☐ Fecha_____
No ☐ Por razones personales_____ Por razones médicas_____

Nombre: _____ Firma del paciente: _____ Fecha: _____

VENTURA COUNTY RADIATION ONCOLOGY MEDICAL GROUP, INC.

ASSIGNMENT OF BENEFITS

This document provides information about your insurance coverage and financial responsibility. Please read this carefully prior to signing below.

Ventura County Radiation Oncology Medical Group, Inc. (VCROMG) will make every effort to obtain authorization for the requested services from your insurance company/carrier. We will also bill your medical carrier directly for the services that we provide.

Your insurance benefits may not cover all the services requested by your physician or they may only pay a portion of the amount that VCROMG bills to them. For example, patients are typically responsible for paying deductibles, co-insurance, and co-payments.

Our Financial Counselors will be happy to answer any questions or concerns you may have regarding your insurance coverage and financial responsibility. Your health is our primary concern. If needed, a Financial Counselor will provide you with additional information on payment plans and financing options to make these payments as easy as possible on you and your family.

By signing this document, you acknowledge and authorize the following:

1. I authorize the payment of medical insurance benefits to VCROMG.

2. I authorize the release of medical information to my insurance company and to any other physicians participating in my medical care.

3. I acknowledge responsibility for the amounts not paid by my insurance company.

4. I agree to meet with the VCROMG's Financial Counselor as necessary to arrange a payment plan for scheduled, current or outstanding balances.

Print Patient Name _____ Date Signed: _____

Patient Signature _____

INSURANCE ELIGIBILITY CERTIFICATION

I understand that it is my responsibility to provide VCROMG with accurate information regarding my Medical Insurance Coverage. Should there be any change in my coverage I agree that I am responsible to notify VCROMG of the changes and understand that should I fail to do so, I will be financially responsible for any resulting unpaid claims.

Print Patient Name _____

Patient Signature _____ Date: _____

Oxnard Center 1700 North Rose Ave, Ste. 120, Oxnard Ca 93030 Phone: (805) 988-2657 Fax: (805) 981-4456
Camarillo Center 5301 Mission Oaks Blvd, Ste. A, Camarillo Ca 93012 Phone: (805) 484-1919 Fax: (805) 987-3977

VENTURA COUNTY RADIATION ONCOLOGY MEDICAL GROUP, INC.

PATIENT REGISTRATION

Name: _____ DOB: _____ Age: _____ Gender: M / F

Address:_____ City: _____

State: _____ Zip Code: _____ Primary Phone (home/cell): _____ Other (home/cell): _____

Do not have email ☐ Decline ☐ Email: _____

Preferred Language: _____ Marital Status: S M W D

Retired/Employed At: _____ Work#: _____

Emergency Contact: _____ Relationship: _____ PH#: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Subscriber Name: _____ DOB: _____ Group#: _____

Secondary Insurance: _____ ID#: _____

Subscriber Name: _____ DOB: _____ Group#: _____

Social Security Number: _____

For Tricare/Triwest Patients: Rank: _____ Military Branch: _____

This information is required for Cancer Registry and Research Purposes

Race: _____ Religion: _____ Ethnicity: Hispanic? Y / N

Place of Birth: _____

All information is true to the best of my knowledge. If there are changes, I will notify the office immediately.

Patient Signature: _____ **Date:** _____

Legal Guardian or Authorized Person: _____ **Relationship:** _____

For Office Use Only:

Account #: _____Primary DX: _____ ICD-9: _____ Referring MD: _____

MD: TOC / HZM Metastatic DX: _____ ICD-9: _____ Phone: _____

Skilled Nursing Facility:_____ Insurance Verified Date/Initials: _____

Oxnard Center 1700 North Rose Ave, Ste. 120, Oxnard Ca 93030 Phone: (805) 988-2657 Fax: (805) 981-4456
Camarillo Center 5301 Mission Oaks Blvd, Ste. A, Camarillo Ca 93012 Phone: (805) 484-1919 Fax: (805) 987-3977

VENTURA COUNTY
RADIATION
ONCOLOGY
MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

RELEASE OF MEDICAL RECORDS & X-RAY

I _____ authorize _____

_____

to release the following medical records to Ventura County Radiation Oncology Medical Group, Inc. Dr. Timothy A. O'Connor and Dr. Henry Z. Montes.

X-Rays: (Please include report!)

PET Scan(s): _____

Bone Scan: _____

MRI Scan: _____

MAMMO: _____

Ultrasound: _____

Other: _____

Medical Record #: _____

Medical Records

H & P: _____

Consult: _____

OP Report: _____

Pathology: _____

Laboratory: _____

Other: _____

Date of Birth: _____ **SS#:** _____

Patient Signature: _____ **Date:** _____

Please fax to:

☐ 805-981-4456- Oxnard Office- Ph # 805-988-2657

☐ 805-987-3977- Camarillo Office- Ph # 805-484-1919

Please mail to:

☐ 1700 North Rose Ave., Suite 120
Oxnard, CA 93030

☐ 5301 Mission Oaks Blvd., Suite A,
Camarillo, CA 93012

☐ By Fed-Ex Account #: _____

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

Ventura County Radiation Oncology Medical Group, Inc.
1700 N. Rose Ave., Suite 120, Oxnard, CA 93030
5301 Mission Oaks Blvd., Suite A, Camarillo, CA 93012
Timothy A. O'Connor, M.D.
(805)-988-2657

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to the personal health, treatment or payment for treatment of.
This request supercedes any prior request for confidential channel communications I may have made. Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

☐ Mail

I want you to contact me at the following address:

_____
Address

_____
City, State Zip

☐ Phone

I want you to contact me by telephone:

Cell Phone: _____
☐ Do ☐ Do not leave voicemail messages.

Home Phone: _____
☐ Do ☐ Do not leave messages on my answering machine.
☐ Do ☐ Do not leave messages with any other person.

Work Phone: _____
☐ Do ☐ Do not leave voicemail messages.
☐ Do ☐ Do not leave messages with any other person.

I hereby give my permission to Ventura County Radiation Oncology Medical Group Inc. to disclose information related to my medical care to the individual(s) listed below (e.g. parent, sibling, child, friend):

NAME	RELATIONSHIP	PHONE NO
NAME	RELATIONSHIP	PHONE NO
NAME	RELATIONSHIP	PHONE NO
NAME	RELATIONSHIP	PHONE NO

Signed: _____ Date: _____

Print Name: _____ Date of Birth: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

****

For office use only:
Date Granted: _____
Date Terminated or Modified: _____

Acknowledgement of Receipt of Notice

Ventura County Radiation Oncology Medical Group, Inc.
1700 N. Rose Ave., Suite 120, Oxnard, CA 93030
5301 Mission Oaks Blvd., Suite A, Camarillo, CA 93012
Timothy A. O'Connor, M. D.
805-988-2657

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that the current notice is available on the company's website: www.rocvc.com.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____
Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

☐ Signed form received by: _____

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____