



6600 66th Street North
Pinellas Park, FL 33781

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Dear Mr., Mrs., Ms., Dr. _____,

We welcome you to WellSpring Oncology. Thank you for the trust you are placing in us to be your caregivers.

This information packet is designed to introduce you to our physicians, staff, Center and the integrated services we offer. In addition, the packet contains three important forms that we ask you to complete *before your first visit*:

- **Patient History**--This important information will allow your doctor to better understand your medical, family and social history.
- **Assignment of Benefits**
- **Consent Forms**

You will also find your "Patient Rights and Responsibilities" that we encourage you to examine carefully. "Advanced Directives" are also available to you upon request.

We have worked very hard to assemble the finest and most caring medical professionals for your personal care. At any point, should you have questions or concerns, feel free to ask any of us. It will be our privilege to help you.

The relationship patients have with their doctors is deeply personal. You have our promise that we will consult with you prior to any treatment so you can make informed choices. We invite you to include your family in this consultation process as well.

We believe in treating the whole person, not just the disease. There are numerous educational and psychosocial resources we can make available to you. Please ask any questions you might have at any time during your treatment with us at WellSpring. We are open Monday-Friday from 7:00a.m. to 5:00p.m. You may also call our WellSpring concierge for assistance.

Should you have an emergency that is life threatening, please call 911. Your physician can also be reached after office hours by dialing 727-343-0600.

Warmest regards,

Frank L. Franzese, M.D.

Robert J. Miller, M.D.

Zucel Solc, M.D.

AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____

SSN#: _____ Telephone #: _____

1. I hereby authorize _____ to disclose to _____ my medical information. This information is to cover the period of _____ and is being disclosed for the purpose of: _____

2. I hereby authorize Dr. _____ and/or his staff to discuss my medical condition and treatment plan with _____

_____	_____
Name of person	Relationship to patient
_____	_____
Name of person	Relationship to patient

3. Medical information to be disclosed (please check all that apply):

- Complete copy of medical record History & Physical Physician Progress notes
- Lab Reports Consultation Reports Nurse/Clinical Notes
- X-Ray Reports X-Ray Films
- Other Diagnostic Reports (please specify) _____
- Redisclosure of records from the following facility: _____
(Patient to initial block when asking for redisclosure)

4. I understand this will include information of a superconfidential nature relating to:
(Patient to check and initial appropriate block)

- Acquired immune deficiency syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV) documentation and/or testing results.
- Psychiatric care documentation
- Alcohol and/or drug abuse documentation

5. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this information. Unless otherwise revoked, this authorization will expire 30 days from the date of this signature.

6. WellSpring Cancer Center, L.L.C., its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

SIGNED: _____ _____
Patient signature *Date*

Legal representative and relationship to patient if patient is unable to sign *Date*

WITNESS: _____ _____
Date 2/08

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Today's Date: _____

Patient's Name: _____ (_____) _____
Last *First* *M.I.* *Home Telephone*

Home Address: _____ Mailing Address: _____
Street *Street*

City *State* *Zip* *City* *State* *Zip*

Date of Birth *Age* *M* *F* *Sex* *Social Security Number* Single Married Divorced Widowed
Marital Status

Employer: _____ (_____) _____
Name *Telephone*

Address *Occupation*

Responsible Party: _____ (_____) _____
Name *Relationship* *Telephone*

Emergency Contact: _____ (_____) _____
Name *Relationship* *Telephone*

Referring Physician: _____ Primary Care Physician: _____

Primary Ins: _____ Telephone: (_____) _____
 Insured Name: _____ DOB: _____ Group#: _____ Policy #: _____
 Secondary Ins: _____ Telephone: (_____) _____
 Insured Name: _____ DOB: _____ Group#: _____ Policy #: _____

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 Well Spring Cancer Center, L.L.C. (WSCC).
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 WSCC. 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 payment to WSCC.
4. I understand that I have a right to request and receive a Notice of Privacy Practices from WSCC.

This Agreement/Consent Shall Remain In Effect Unless Revoked By Me In Writing

I have read and received a copy of the above statement and accept the terms. A duplicate of the statement is considered the same as original.

Patient's Signature	Date/Time:	a.m./p.m. Circle one
Responsible Party Signature	Relationship	Date/Time:
Witness	Date/Time:	a.m./p.m. Circle one

CONFIDENTIAL



HEALTH HISTORY QUESTIONNAIRE

Name: _____ D.O.B.: _____ Date: _____

Referring Physician: _____ Family Physician: _____

Other physicians involved in your care: _____

In order for us to develop a comprehensive treatment plan, we need to clearly and completely understand your current and past medical history. In preparation for your consultation with Dr. _____, please take a moment to provide the following information. Everything disclosed here will be kept **strictly confidential**, but please feel free to leave blank any areas you are unclear on or do not wish to provide.

What is your primary medical reason (diagnosis) that brings you to our office?

Please give a brief history of your current problem (when it started; symptoms; impact on daily living):

Have you received any treatment for your **current** diagnosis of cancer? (Please **list** the type and date of treatment you have received including **prior surgery, chemotherapy, hormone therapy, radiation treatment and/or complimentary/alternative therapies**).

If you have had **prior** cancers (before current illness), please list them and how they were treated:

Allergies: ___ Yes ___ No

List all **Allergies** and describe your reaction:

Medications including vitamins, minerals, herbal and nutritional supplements: (Please list and bring to appt.)

Medication/Supplement	Dose	Frequency (times per day)	Started	Stopped

Medical History: (Please check all current or previous illnesses or conditions.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes/Pre-diabetes | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Alzheimers/Dementia |
| <input type="checkbox"/> Environmental/Food Allergies | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Pneumonia/Bronchitis | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Emotional/Mental Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Colitis/Chrohn's | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Bone Disease/Osteoporosis |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Other (please list below) |

Health Maintenance: (Please circle if you had the test and list date when last performed.)

Colonoscopy _____ Mammogram _____ PSA _____
 Bone Density _____ Pap Smear _____

Other Surgeries and Previous Hospitalizations: (Please list what/where and date)

Social History:

What is/was your occupation? _____

Are you retired? _____ Education through grade? _____

Have you been exposed to any chemicals or radiation? _____

Whom do you live with? _____

Do you have children and their ages? _____

Hobbies/Exercise: _____

Spiritual/Religious Practices or Needs: _____

Do you have Transportation/Financial Needs? _____

Tobacco Use (presently or in the past): ____ **Yes** ____ **No** If you indicated **Yes**, list the type of tobacco products you have or currently use and amount per day, the date/age you started and stopped(if applicable):

Exposure to second-hand smoke: ____ **Yes** ____ **No**

Alcohol Use: ____ **Yes** ____ **No** If you indicated **Yes**, list the type and amount of alcohol you currently or previously drank and the date/age you started and/or you quit:

Family History: (*Living or deceased, age, cancer diagnosis or cause of death*)

Father: _____

Mother: _____

Grandparents: _____

Siblings: _____

Children: _____

Review of Systems: (*Please circle any symptoms you have experienced in the last six months.*)

1. General:

*Weight loss/gain Changes in appetite Dietary restrictions/food intolerances
Problems sleeping Energy loss/fatigue Inability to perform normal activities*

2. Pain:

Are you in pain? ____ No ____ Yes _____ Location _____ Character _____ Severity

3. Head and neck:

*Visual changes Ringing in ears Hearing loss Ear Pain Nose bleeds
Mouth pain Difficulty swallowing Dental problems Hoarseness Facial Swelling*

4. Pulmonary (lungs):

*Shortness of breath at rest/with exertion Pain with deep breathing Cough
Coughing up blood Oxygen at home Wheezing*

5. Heart/cardiovascular:

Chest pain Irregular heartbeat Facial/arm swelling Swelling in legs
Leg ulcers Trouble lying flat Leg pain with walking

6. GI (stomach/intestine):

Nausea /Vomiting Diarrhea Constipation Indigestion Vomiting blood
Blood in bowel movements Black/tarry stools Pain with bowel movements
Bowel incontinence

7. GU (bladder/kidneys):

Burning/pain with urination Blood in urine Frequency Urgency
Dribbling Unable to control bladder

8. Musculoskeletal (bone/joints/muscles):

Bone/back pain Trouble walking/falls Muscle pain Stiffness Swelling

9. Neurological (brain):

Headaches Confusion Seizures/Tremors Balance problems Dizziness/fainting
Weakness Speech problems Memory changes/Confusion Numbness/tingling

10. Psychological:

Worried/anxious Sad/depressed Feeling helpless

11. Hematology/Lymph:

Fever Chills Frequent Infections Bleeding/Bruising
Blood transfusions Swelling Groin/armpit/neck

12. Endocrine:

Excessive thirst or urination Hot flashes Cold intolerance

13. Skin:

Rashes Sores that don't heal/ulcers Change in moles Nodules Hives Skin Cancer

14. Gynecologic (females only):

Breast mass/lump Prior breast biopsies Nipple discharge Breast inflammation/tenderness
Age when started period_____ Last menstrual period_____ Unusual bleeding/discharge
Years of birth control use____ Years on hormone replacement ____ Number of pregnancies_____
Live births_____ Age at first pregnancy_____ Pain with intercourse Loss of sexual desire

15. Gynecologic (male):

Problems with passing urine Lump on testicle Difficulty with erections Loss of sexual desire

16. Other (please describe any other symptoms):

Our **mission** at WellSpring is to support both the physical and emotional needs of the patient and family. We understand that receiving a diagnosis of cancer can be frightening and confusing. We invite you to share any additional concerns or feelings. By understanding your needs, we can work together to provide comprehensive and compassionate care and support your return to health.

Patient Signature/Date

Reviewed with Patient by Physician/Nurse and Date



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All of us at WellSpring are pleased to have you as a new patient. Please take a moment to let us know how you heard about us. We thank you for this help and look forward to having you here.

1. How did you hear about us? (check as many as apply)

- Your Doctor's referral
- A friend
- Radio
- TV
- Internet search
- Other _____

2. Where did you get our contact information?

- Doctor gave me your info
- Phonebook
- Radio/TV
- Internet search
- Other _____

3. What other doctors did you consider seeing besides those at WellSpring?

4. Have you seen any of our WellSpring billboards?

YES NO If "Yes" where? _____

5. Have you heard any of our radio ads?

YES NO If "Yes" what radio station? _____

6. Have you seen us on any television programs?

YES NO If "Yes" what station and program? _____

7. From what you've heard, what are we best known for?

- Great doctors
- State of the art technology
- Caring staff
- Beautiful facility
- Other _____

THANK YOU!