ICS
Iowa Cancer Specialists

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# Functional Medicine Consult

Your physician's office has scheduled an appointment for you in our Davenport office.

You will be seeing Dr. Linda Jager

**If you are unable to fill out the paperwork prior to your appointment. PLEASE ARRIVE 30 mintues prior to your appointment in order to fill out the necessary paperwork and provide us with the necessary identification. If you are unable to arrive 30 minutes early, please call us as we will need to reschedule your appointment.**

**Reminder -** Please **bring your MEDICATIONS and Supplements** with you to your appointment as well as **your insurance cards.** Co-payments are required the day of the service. **You will need to provide us with your social security number and a street address. If you cannot provide this information please be prepared to pay for your visit in full the day you are seen or reschedule your appointment for a later date.**

**If you do not have insurance please call our office at 563-345-HEAL (4325) to speak with the billing department to make payment arrangements before your visit.**

If you have any questions or need directions to our office, please call.

Sincerely,

Linda Jager, M.D.
Iowa Cancer Specialists

Encls.

IOWA CANCER SPECIALISTS, PC

# PATIENT INFORMATION

Date: _____ Referring Physician: _____

Family Physician: _____

**Patient Information:**

| | |
|---|---|
| Patient's Name: | S.S. #: |
| Patient's Address: | Date of Birth: |
| City/State: | Zip: |
| Home Phone: Cell Phone: | Preferred Method of Contact: |
| Patient's Employer: | Occupation: |
| Business Phone: Ext: | Hours: |
| Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced | E-mail: |
| Sexual Orientation: [ ] Heterosexual [ ] Homosexual [ ] Bisexual [ ] Choose not to disclose | Birth Gender: [ ] Male [ ] Female |

**Spouse or, if patient is a minor, financially responsible parent (Mother or Father)**

| | |
|---|---|
| Spouse/Parent Name: | Home Phone: |
| Address: | Date of Birth: |
| | S.S. #: |
| Employed by: | Work Phone: |

**Insurance Information**: (Please check one) Please give Front Office a copy of all cards

Medicare: ____ Iowa Public Aid: ____ United HealthCare: _____

BC/BS: _____ Other: _____

| | |
|---|---|
| Insurance #: | Subscriber Name:<br>DOB: |
| Sequence #: | Group #: |
| Name of Private or Secondary Insurance: | Subscriber Name: |
| Address: | City/State/Zip: |

**NAME OF NEAREST RELATIVE OR FRIEND TO NOTIFY IN CASE OF AN EMERGENCY**

Name: _____ Relationship to You: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____ Ext: _____

Do you have a Living Will? [ ] Yes [ ] No

**PLEASE SIGN THE BACK OF THIS FORM AND GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO COPY**

## INSURANCE AND MEDICAL POLICY INFORMED CONSENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to Iowa Cancer Specialists, PC (ICS) for any services furnished to me by ICS. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have additional insurance policies, my signature authorizes releasing information to the insurer or agency shown. In Medicare or other insurance company assigned cases, the doctor will accept the charge and determination of Medicare or the other insurance as the full charge and the co-insurance and the deductible are based upon the charge determination of Medicare or the other insurance company.

I also understand that my signature authorizes ICS to perform medical testing and/or treatment which may include, but are not limited to, blood tests, bone marrow, lumbar puncture, and/or chemotherapy, if necessary.

Signature:_____Date:_____

Print Name:_____

# Iowa Cancer Specialists, P.C.

**Information for Your Physician**

Please answer the following questions prior to your first examination.

**Name:** _____ **Date:** _____

| | |
|---|---|
| **Primary Language:** _____<br>**Religion:** | **Ethnicity: Hispanic / Latino origin? Yes No**<br>**Race (Please circle each that apply):** White/Caucasian Black/African American Asian Hawaiian American Indian Alaskan Other: _____ |
| **Family History:** | **Health / Illnesses or Cause of Death** |
| Father: Living / Deceased | |
| Mother: Living / Deceased | |
| Brothers: Living___/Deceased: ___ | |
| Sisters: Living___/Deceased: ___ | |
| Children: Living___/Deceased: ___ | |

**Patient History (Please list approximate dates):** **Marital Status:** _____

**Your Sex at Birth: [ ] Male [ ] Female** Gender Identity: [ ] Male [ ] Female

**Circle Any Illnesses /Conditions You Have Had:** Glaucoma Sexually Transmitted Disease Asthma Jaundice Pneumonia Bleeding Tendencies Tuberculosis Kidney Disease Rheumatic Fever Other: _____
Heart Problems (Irregular Heartbeat, Attack, etc.): _____ Cancer (What kind?): _____

| | |
|---|---|
| **Present or Previous Type of Employment:** | **Hospitalizations:** |
| **Injuries:** | **Past Procedures:** |
| **Immunizations: (Circle all that apply)**<br>Small Pox Tetanus Typhoid Polio Influenza Pneumonia Shingles Other: _____ | **Surgeries:** |
| **Have you taken Cortisone type drugs? Yes No** | **Have you received a blood Transfusion? Yes No** |
| **Do You Use Tobacco Now? Yes No**<br>In the Past: Y N How Long: _____<br>Type/Daily Amt: _____ | **Do You Use Alcohol Now: Yes No**<br>In the Past: Y N How Long: _____<br>Type/Daily Amt: _____ |

**Women:** Onset of Last Menstrual Period: _____ Regular / Irregular Post-Menopausal? **Yes No**
Pregnancies: _____ Miscarriages: _____ History of Oral Contraceptives? **Yes No**

**Have You Had Allergy or Sensitivity to Medicines or Other Substances? Yes No**
If so, please list:

**PLEASE BRING ALL OF YOUR MEDICATION BOTTLES OR A COMPLETE UP-TO-DATE LIST OF MEDICATIONS.**

# IOWA CANCER SPECIALISTS, PC
# HIPAA Form

Consent for Release and Use of Confidential Information,
and Receipt of Notice of Privacy Practices Form.

I, _____ hereby give consent to Iowa Cancer Specialists
(Name of Patient or Authorized Representative)
(ICS) to use or disclose, for the purposes of carrying out treatment, payment, or health care operations,

all information contained in the patient record of _____.
(Patient Name)

I acknowledge receipt of the Physician's Notice of Privacy Practices which provides detailed information about how the practice may use and disclose my confidential information.

I understand that the Iowa Cancer Specialists has reserved the right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me upon my request.

I authorize the release of information to be given to the following persons:

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

I request the following restrictions for the use and disclosure of my health information:

_____

_____

I authorize ICS to leave messages on my home phone or cell phone for general messages or for appointment scheduling changes. YES NO

I authorize ICS to contact me at my place of employment if unable to reach me at my phone number. YES NO

_____ _____
(Signature of Patient / Authorized Representative) Date Signed

# Initial Questionnaire

The single most important criteria for effective case management is a comprehensive and detailed health history. Please answer the following questions with as much detail as possible. It is important for me to know everything about you and your case. Even when you feel the questions may not be directly relevant to your situation, please do your best to answer them.
Instructions: Please legible write answers to the following questions with as much detail as possible. Please answer each question independently.

## HEALTH HISTORY QUESTIONS

**1) Please list the following:**
Education:
Profession:

Interests (sports, hobbies, etc.):

**2) List your chief complaints in order of their importance to you:**

**3) List all diagnoses given to you in a timeline sequence and your personal opinions about them:**

**4) What is your opinion of what has happened to your health?**

**5) List any treatments, medications, or supplements that have improved your health:**

**6) List any treatments, medications, or supplements that have caused reactions or decreased your health:**

**7) List in a timeline sequence any medical procedures or surgeries you have had:**

# Personal Opinion Questions

**Please do not answer "I don't know" to any of these questions.**

**What are you looking for in a healthcare practitioner?**

**2)What do you consider a realistic window of time to see changes in your health under our care?**

**3)Are you prepared to pay for the laboratory testing, consulting fees, and nutritional supplements that may be required to successfully manage your condition?**

**4) On a scale of 1 to 10, how committed are you to recovering your health?**

**Why?**

**5) What obstacles or beliefs, if any, stand in the way of you recovering your health?**

**6) Are there emotional or psychological issues that may be contributing to your health problems? If so, please explain them briefly.**

**7) Do you enjoy your work? Do you believe your work contributes to your health problems?**

**8) Do you have a purpose in life?**

**9) Where else do you find support? Friends? Church or religious group? Nature?**

**10) How did you feel about answering all of these questions and the case review process?**