

NEW PATIENT REGISTRATION FORM

Please take a minute to complete this form to assist us in updating our records.
Please have your driver's license and Insurance card ready. Thank you!

Patient Information

Patient Name _____

Date of Birth ____/____/____ SSN _____

Male Female

Marital Status: Married Widowed Single Divorced

Have you had a flu vaccine this flu season (Sept-March) (circle one): Yes No
Were you in a hospital, skilled nursing facility, emergency room, or other setting of care
before your visit today (circle one): Hospital Skilled nursing facility ER Other

Contact Information

Mailing Address _____ City _____

State _____ Zip _____ County _____ Email Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Contact Preference Home Work Cell

Spouse/Next of Kin _____ Relationship/Phone _____

Emergency Contact _____ Relationship/Phone _____

Employer/Address _____

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Phone _____

NEW PATIENT & FAMILY HISTORY

Patient Name: _____ Date _____

Referring Physician _____ DOB _____ Height/Weight _____

Chief Complaint: (Please explain the reason you are here today):

PAST MEDICAL HISTORY:

Prior cancers: Yes ___ No ___

Prior radiation: Yes ___ No ___

Prior chemotherapy: Yes ___ No ___

Pacemaker: Yes ___ No ___

PAST SURGERIES: None _____

List any surgeries (including surgery for this cancer diagnosis, if applicable) and date performed.

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES: List all allergies and reactions: _____

Preventative Health Maintenance: Please provide dates for each answer or write "none"

Last Mammogram: _____

Last Colonoscopy _____

Last Prostate Exam _____:

Last Breast Biopsy: _____

Last Pap Smear: _____

Last Upper Endoscopy: _____

Last PSA Screening _____

Last Bone Density Scan: _____

Last Breast MRI: _____

Last Pneumonia Vaccine: _____

Please ✓ any of the items that apply to you or that you may be experiencing.

You may write any explanation you feel is pertinent next to the appropriate symptom.

Example: Fatigue-since surgery, etc.

SOCIAL HISTORY:

Occupation: _____

Marital Status: single married divorced widowed

Lives with _____ Transportation _____

Do you smoke? YES NO

IF YES, estimate how many packs a day: _____

IF YES, how many years have you smoked? _____

Are you a former smoker? YES NO

IF YES, how many years did you smoke? _____

IF YES, when did you quit smoking? _____

IF YES, estimate how many packs per day? _____

Do you drink alcoholic beverages? YES NO

IF YES, how many drinks do you have per week? _____



Do you have a history of recreational drug use? YES NO

GENERAL:

Normal Weight: _____ Recent Weight Loss Amt: _____ Recent Weight Gain- Amt: _____

Loss of Appetite Fatigue Weakness Fevers Chills Night Sweats

EYES:

Glaucoma Cataracts Double vision Change in vision Other vision problems

EARS / NOSE / THROAT:

Loss of hearing Nose Bleed Sore throat Difficulty swallowing

Ringing in ear(s) Hoarseness Dentures Pain upon swallowing

Earache Dry mouth Dental problems Loss of taste Diabetes

CARDIOVASCULAR:

Pacemaker Irregular heartbeat Difficulty swallowing Short of breath when lying down

Chest pain Fainting spells Oxygen use at home Heart Attack

RESPIRATORY:

Shortness of breath Dry cough Coughing up sputum Coughing up blood

GASTROINTESTINAL:

Heartburn Jaundice Diarrhea Hemorrhoids / fissures Nausea or vomiting

Constipation Blood in stool Recent change in bowel movements Abdominal pain

How often do you have a bowel movement?

GENITOURINARY:

Difficulty urinating Color change of urine Painful urination

Up at night to pass urine Sexual difficulties Blood in urine

How often do you urinate: during the day? _____ during the night?

WOMEN ONLY:

Menopause Hot flashes Hormone therapy Currently sexually active

Date of last menstrual period: _____ Number of pregnancies: _____ Number of live births: _____

MEN ONLY:

Currently sexually active Penile discharge Testicular pain Difficulty with erections

Testicular mass

MUSCULOSKELETAL:

Leg cramps Painful muscles Painful joints Artificial joints

SKIN & BREASTS:

Itching Pain in breast Discharge or bleeding from nipple

Rash Nipple inversion Change in size, shape or contour of breast

Color changes Change in nipple Lump or mass in breast or armpit

NEUROLOGICAL:

Headaches Difficulty with words Loss of consciousness

Tremors Dizziness Difficulty with balance

Memory Loss Seizures Numbness or tingling Stroke

PSYCHIATRIC:



- Nervousness
- Depression
- Anxiety
- Change in personality

HEMATOLOGIC & LYMPHATIC:

- Swollen lymph glands
- Excessive bruising
- Excessive bleeding

ENDOCRINE:

- Excessive thirst
- Excessive urination

Referring Physician

Physician's Name _____

Contact Information: _____

Physician's Name _____

Contact Information: _____

Medications

MEDICATIONS: Please list all medications, including prescription, non-prescription, and other (including herbal) that you are currently taking. Please include dosage and frequency taken.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above: _____

Patient Signature _____

Printed Name _____

Date _____



Assignment of Benefits/Financial Responsibility

Patient Name _____

Date of Birth ____/____/____ SSN _____

Marital Status: Married Widowed Single Divorced

Mailing Address _____ City _____

State ____ Zip ____ County _____ Email Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Contact Preference Home Work Cell

Spouse/(Next of Kin) _____ Relationship/Phone _____

Employer/Address _____

Primary Insurance _____ Policy Holder _____

Policy Holder DOB _____ SSN _____

Secondary Insurance _____ Policy Holder _____

Policy Holder DOB _____ SSN _____

Policy Holder 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 Alabama Cancer Care, LLC. I also authorize agents of any hospital, treatment center or previous physician to furnish Alabama Cancer Care, LLC copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within Alabama Cancer Care, LLC.

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 Alabama Cancer Care, LLC. 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 Alabama Cancer Care, LLC.

4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology. 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.

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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.

Patient Signature

Date

Responsible Party Signature

Relationship

Date



Authorization for Release of Information

1. I hereby authorize _____ to release information including, if any psychiatric or psychological information, infectious or contagious disease information (including AIDS confidential information, and/or information about drug or alcohol abuse or treatment of the same) for the health records of: _____

Covering the periods from: _____ to: _____

Date of Birth: _____ SSN#: _____

2. Information to be released:

- Copy of Radiation Oncology Records
- Pathology
- History & Physical
- Diagnostic Reports
- Port Films
- Other _____

3. Information to be released to: (Please include name and address):

4. Purpose or disclosure: _____

5. I have read and understand the Consent for Release of medical records to Alabama Cancer Center and their clinics and have voluntarily and knowingly signed such consent.

Signature of Patient

Date

Signature of Patient Representative

Date

HIPAA Notice of Privacy Practices Acknowledgement

Patient Name: _____ DOB: _____

By law, the HIPAA Privacy Rule Prohibits Alabama Cancer Care, LLC from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. This Rule became effective April 14, 2003.

1) Please list the names of all persons that you wish to have access to your Protected Health Information (PHI) (i.e. those making appointments or checking on test results for you):

Name	Relationship	Restrictions
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Name	Relationship	Restrictions
------	--------------	--------------

Name	Relationship	Restrictions
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Name	Relationship	Restrictions
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Name	Relationship	Restrictions
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By signing below, I give Alabama Cancer Care, LLC authorization to release my personal information as listed.

I acknowledge that I have received the attached Notice of Privacy Practices:

Patient Name or Personal Representative

Date

Print Patient/Representative Name

If Personal Representative's signature appears above, please describe Personal

Representative's relationship to the patient: _____



Family Medical History

Patient Name _____

Date of Birth ____/____/____ SSN _____

All family history questions apply only to your biological family. Anyone to whom you are related through adoption or marriage (i.e. step-family) does not apply. If you need more room, please complete your answer on the back of this page.

Biological Father: My father is: ___ living ___ deceased ___ unknown

If deceased, please indicate the cause of death and age: _____

List your father's medical problems: _____

Biological Mother: My mother is: ___ living ___ deceased ___ unknown

If deceased, please indicate the cause of death and age: _____

List your mother's medical problems: _____

Biological Sister/Brother: My Sister/brother is: ___ living ___ deceased ___ unknown

If deceased, please indicate the cause of death and age: _____

List your sister/brother's medical problems: _____

Biological Children: Number of Children: ___ living ___ deceased

If deceased, please indicate the cause of death and age: _____

List your children's medical problems: _____

Please indicate if your biological family has any of the following: M-mother, F-father, S-siblings, C-children-P-patient

Heart Disease M ___ F ___ S ___ C ___ P ___

Cancer M ___ F ___ S ___ C ___ P ___

High Blood Pressure M ___ F ___ S ___ C ___ P ___

Stroke M ___ F ___ S ___ C ___ P ___

Type _____
Blood Disorder Cancer M ___ F ___ S ___ C ___ P ___

Kidney Disease M ___ F ___ S ___ C ___ P ___

Emotional Problems M ___ F ___ S ___ C ___ P ___

Cholesterol Problems M ___ F ___ S ___ C ___ P ___

Type _____

Diabetes M ___ F ___ S ___ C ___ P ___

Thyroid Disease M ___ F ___ S ___ C ___ P ___

