# 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_____

Todd Scarbrough MD, Radiation Oncology
Ashvini Sengar MD, Hematology/Oncology

Alabama CancerCare®

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# NEW PATIENT & FAMILY HISTORY

Patient Name: _____Date_____

Referring Physican_____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: _____

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Physician's Name_____

Contact Information: _____

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## 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: _____

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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_____

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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

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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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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

Alabama CancerCare®

# 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 |
|---|---|---|
| Name | Relationship | Restrictions |
| Name | Relationship | Restrictions |
| Name | Relationship | Restrictions |
| Name | Relationship | Restrictions |

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

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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___
High Blood Pressure M___F___S___C___P___
Stroke 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___
Diabetes M___F___S___C___P___

Cancer M___F___S___C___P___

Type_____
Blood Disorder Cancer M___F___S___C___P___

Type_____
Thyroid Disease M___F___S___C___P___

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