

# 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  $\checkmark$  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.

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.

---

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
------	--------------	--------------

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

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 \_\_\_\_\_

Kidney Disease M \_\_\_ F \_\_\_ S \_\_\_ C \_\_\_ P \_\_\_

Blood Disorder Cancer M \_\_\_ F \_\_\_ S \_\_\_ C \_\_\_ P \_\_\_

Emotional Problems M \_\_\_ F \_\_\_ S \_\_\_ C \_\_\_ P \_\_\_

Type \_\_\_\_\_

Cholesterol Problems M \_\_\_ F \_\_\_ S \_\_\_ C \_\_\_ P \_\_\_

Thyroid Disease M \_\_\_ F \_\_\_ S \_\_\_ C \_\_\_ P \_\_\_

Diabetes M \_\_\_ F \_\_\_ S \_\_\_ C \_\_\_ P \_\_\_