Coastal Radiation Oncology
21st Century Oncology Affiliate

# *Patient Registration Form*

| Today's Date: | **OFFICE USE ONLY** | |
|---|---|---|
| | Rendering M.D.: | DX CODE: |

**PATIENT INFORMATION**

| Patient's Last Name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital Status: ☐ Single ☐ Married ☐ Widow |
|---|---|---|---|---|---|

| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | Social Security No.: | Birth Date: | Age: | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|

| Street address: | City: | State/Zip: | Home Phone: | Cell Phone: |
|---|---|---|---|---|

***Attention:*** We will use all phone numbers to contact you regarding appointment reminders, test results, issues regarding your treatment, collection purposes or other issues regarding your information.

| Race: | Ethnicity: | Primary Language: | Email: |
|---|---|---|---|

| Employer: | Occupation: | Employer Phone No.: | Employment Status: ☐ Retired ☐ Full Time ☐ Part Time ☐ Student |
|---|---|---|---|

| Family Doctor: | Phone No.: |
|---|---|

| Referring Doctor Last Name: | First: | Phone No.: | Fax No: |
|---|---|---|---|

Are you currently in Assisted Living or a SNF? YES NO If Yes - Name of Facility:

**EMERGENCY CONTACT**

| Full Name: | Birth Date: | Relationship to the patient: | Phone No.: | Cell No.: |
|---|---|---|---|---|

**RESPONSIBLE PERSON, IF OTHER THAN THE PATIENT**

| Person responsible for the bill: | Birth Date: | Relationship to the patient: | Phone No.: | Cell No.: |
|---|---|---|---|---|

Address (If different):

| Employer: | Occupation: | Employer Phone No.: | Employment Status: ☐ Retired ☐ Full Time ☐ Part Time ☐ Student |
|---|---|---|---|

**INSURANCE INFORMATION**

(Please give your Insurance Card and Driver's License to the Receptionist to copy)

Type of Payment: ☐Cash ☐Insurance ☐ Medicare ☐Medical / Medicaid ☐ Workers Comp ☐ VA Benefits ☐ Other:

| **Primary Insurance** | **Secondary Insurance** | **Other Coverage** |
|---|---|---|
| Insurance Type: ☐PPO ☐HMO ☐EPO | Insurance Type: ☐PPO ☐HMO ☐EPO | Insurance Type: ☐PPO ☐HMO ☐EPO |
| Insurance Co.: | Insurance Co.: | Insurance Co.: |
| Address: | Address: | Address: |
| Phone No.: | Phone No.: | Phone No.: |
| Insured Name: | Insured Name: | Insured Name: |
| Relation to Subscriber: | Relation to Subscriber: | Relation to Subscriber: |
| Policy/ID#: | Policy/ID#: | Policy/ID#: |
| DOB: | DOB: | DOB: |

**ACKNOWLEDGMENT**

The above information is true of the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for any balance. I also authorize the name of the practice mentioned above or insurance company to release any information required to process my claims.

_____ _____

***Patient /Guardian Signature*** ***Date***

Coastal Radiation Oncology
Affiliate of 21st Century Oncology, LLC

COASTAL MD: _____

# HEALTH QUESTIONNAIRE

Name: _____ City: _____ Date: _____

DOB: _____ Age: _____ Marital Status: _____

Present Occupation: _____ Retired: □ Yes □ No

Nearest Relative or Friend to contact: _____ Phone: _____

Please name ALL of your doctors: _____

_____

_____

Are you currently taking any medications? Yes ☐ No ☐ **If yes, please complete medications list**

Are you allergic to any medications or other substances? Yes ☐ No ☐ **If yes, please complete medication list**

Do you need assistance walking? Yes ☐ No ☐ If Yes do you use: Cane ____ Walker _____ Wheelchair _____

Have you had the Flu Vaccination? Yes ☐ No ☐ If Yes when: _____

Have you ever been exposed to prolonged x-rays or other radiation (other than routine diagnostic studies)?

Yes ☐ No ☐ If yes, please explain: _____

Name of Family Members or Caregivers with you today: _____

_____

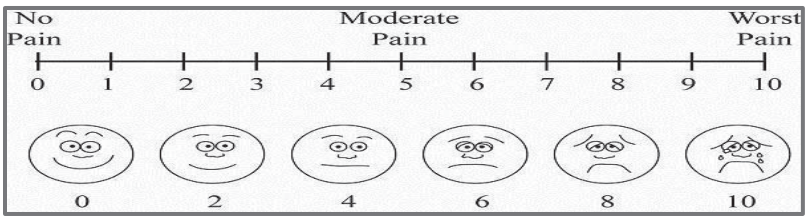
## PAST MEDICAL HISTORY

| | Yes | No | Year | | Yes | No | Year |
|---|---|---|---|---|---|---|---|
| Headaches | □ | □ | ____ | High blood pressure | □ | □ | ____ |
| Seizures/Epilepsy | □ | □ | ____ | Abnormal heart beat | □ | □ | ____ |
| Loss of consciousness | □ | □ | ____ | Duodenal/Stomach Ulcer | □ | □ | ____ |
| Glaucoma | □ | □ | ____ | Gallbladder trouble | □ | □ | ____ |
| Eye pain | □ | □ | ____ | Liver disease/Hepatitis | □ | □ | ____ |
| Change in vision | □ | □ | ____ | Blood in stool/Black tarry stool | □ | □ | ____ |
| Hay fever | □ | □ | ____ | Diarrhea | □ | □ | ____ |
| Hoarseness/Voice change | □ | □ | ____ | Last Colonoscopy | □ | □ | ____ |
| Trouble swallowing | □ | □ | ____ | Last Sigmoidoscopy | □ | □ | ____ |
| Dentures | □ | □ | ____ | Nausea/Vomiting | □ | □ | ____ |
| Asthma | □ | □ | ____ | Loss of appetite | □ | □ | ____ |
| Shortness of breath | □ | □ | ____ | Weight loss | □ | □ | ____ |
| Cough up blood | □ | □ | ____ | Jaundice | □ | □ | ____ |
| Tuberculosis | □ | □ | ____ | Hemorrhoids | □ | □ | ____ |
| Emphysema | □ | □ | ____ | Urinary problems | □ | □ | ____ |
| Thyroid problems | □ | □ | ____ | Pain with urination | □ | □ | ____ |
| Skin disease | □ | □ | ____ | Loss of bladder control | □ | □ | ____ |
| Skin cancers | □ | □ | ____ | Kidney disease | □ | □ | ____ |
| Chest pain/Angina | □ | □ | ____ | Diabetes | □ | □ | ____ |
| Heart Attack/MI | □ | □ | ____ | Arthritis | □ | □ | ____ |
| Ankle Swelling | □ | □ | ____ | Joint pains | □ | □ | ____ |
| Cancer | □ | □ | ____ | Back pain | □ | □ | ____ |
| Pace Maker | □ | □ | ____ | Rheumatic fever | □ | □ | ____ |

Other (please explain): _____

**PAIN:** Are you in pain now? Yes: ☐ No: ☐ If yes, where is your pain? _____

On a scale of 0 to 10, 10 being the worst, please rate your pain:
**Circle Number** →




If pain is more than none or 0 physicians will assess and determine pain management plan for patient.

## SURGICAL HISTORY

Surgery/Illness: _____ Date: _____

Surgery/Illness: _____ Date: _____

Surgery/Illness: _____ Date: _____

## FAMILY HISTORY

If a parent, grandparent, brother, sister or child has had any of the following diseases, please check:

| | Mother | Father | Sibling | Child | Grandparent | Other |
|---|---|---|---|---|---|---|
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| If yes, what was cancer site? _____ | | | | | | |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Other (please explain) _____

## PERSONAL HISTORY AND HABITS

Birthplace and date: _____

Number of children: _____ Ages: _____

Age of spouse (if living): _____ Years married: _____

Major health problems/cause of death: _____

Do you smoke? Yes ☐ No ☐ Number of packs a day: _____

Number of years: _____ Year you quit: _____

Do you drink alcohol? Yes ☐ No ☐ Type / amount used (beer, wine, mixed drinks): _____

## THIS SECTION IS FOR WOMEN ONLY

Are your menstrual periods regular? Yes ☐ No ☐

Have your menstrual periods stopped? Yes ☐ No ☐

If yes, when? _____

Age your menstrual cycles began? _____

Date of last pap smear: _____

Do you have spotting between periods? Yes ☐ No ☐

Do you have vaginal discharge? Yes ☐ No ☐

**Are you pregnant now or could you be? Yes ☐ No ☐**

Number of pregnancies: _____

Date of last mammogram: _____

***Office Use Only*** ***Staff Initials:*** _____ ***Doctors Initials:*** _____

Height: _____ Weight: _____ Med List Completed & Attached ☐

BMI: _____ Within Nutritional Perimeters Yes ☐ No ☐ Nutritional Guidance Handout Given ☐

☐ Current Smoker: Yes, Smoking Cessation Handout Given ☐ Mammogram: Received (15 months) ☐

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**Patient Name:** _____ **DOB:** _____

**Date of Visit:** _____ **Doctor:** _____

# Personal Medications

**List all allergies (*Medication, Food, etc.*)**

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Preferred Pharmacy & Location:** _____

**List all Medications you are currently taking:**

***Prescription Medications, Over the Counter Medications, Herbal Supplements or Vitamins.***

| Medication | Dosage (mg) | Frequency *(ex: 1x a day / as needed, etc.)* | Route of Administration *(Orally, eye drops, IV, Rectal)* |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

**Are you currently taking Hormonal Therapy? Yes** ☐ **No** ☐ **If yes name:** _____

**Are you currently undergoing Chemotherapy: Yes** ☐ **No** ☐

**Staff Initials:** _____ **Doctors Initials:** _____

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## RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP)

We are required by law to make a good faith effort to supply you with our Notice of Privacy Practices and obtain an acknowledgement from you. Your signature below demonstrates that a copy of our Privacy Practices was given to you. However, your receipt of care and treatment from 21st Century Oncology and its subsidiary, Coastal Radiation Oncology Medical Center, is not conditioned upon your providing a written acknowledgment.

I acknowledge that I have received a copy of 21st Century and its subsidiary, Coastal Radiation Oncology Medical Center Notice of Privacy Practices.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient if Signed by Representative

***A copy of the HIPPA Privacy Policy is available for your records***

## ASSIGNMENT OF MEDICARE AND **OTHER INSURANCE** BENEFITS (AOB)

*Lifetime Signature Authorization*

_____ _____

Name of Subscriber if Different from Patient Subscriber DOB

***Medicare Benefits***

I request that payment of authorized Medicare benefits be made on my behalf to Coastal Radiation Oncology Medical Center for any services furnished to me by that physician(s) supplier. 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 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 other health insurance coverage is indicated on Item 9 of the HCFA-1500 claim form or on other approved claim forms or electronically submitted claims my signature authorizes release of the information to the insurer or agency shown.

***Other Insurance Benefits***

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Private Insurance, HMO Insurance and other insurance to Coastal Radiation Oncology Medical Center.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the case of HMO Insurance I am responsible for all services not referred and/or authorized by my Primary Care Physician. I hereby authorize said assignee to release all necessary information to secure such payment.

_____ _____

Patient Signature Date

Coastal Radiation Oncology
21st Century Oncology Affiliate

**COASTAL MD:** _____

# RELEASE OF INFORMATION TO OTHER

Date: _____

Patient Name: _____ DOB: _____

**OPTION 1:**

_____ I would like the following people to be allowed to ask any questions or request any information about my Radiation Treatment:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

**OPTION 2:**

_____ I do not give anyone permission to ask any questions regarding my treatment or medical records other than myself.

_____ _____
Patient Signature Date

_____ _____
Signature of Witness Associate Date