Coastal Radiation Oncology
Affiliate of 21st Century Oncology, LLC

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 an assisted living facility 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 ☐Medi-cal / 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 to the best of my knowledge. I authorize my insurance benefits to 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*

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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 medication 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 a: 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: _____

_____

Do you have a medical Durable Power of Attorney? Yes □ No □ Do you have an Advanced Directive? Yes □ No □

Do you have a Living Will? Yes □ No □ ***If you answered yes to any of the above questions, please provide a copy.**

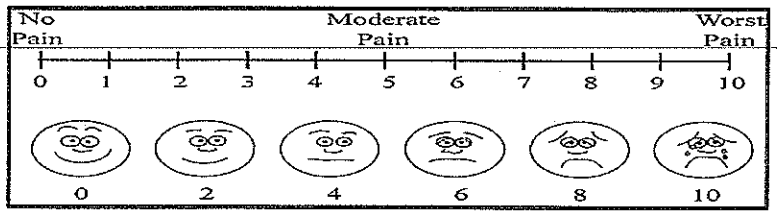
PAST MEDICAL HISTORY

	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 a 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, sibling or child has had any of the following diseases, please check:

	Mother	Father	Sibling	Child	Grandparent	Other
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐

If yes, what was cancer site? _____
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: _____
Have you ever smoked? Yes ☐ No ☐ Number of packs per day: _____
Number of years smoked: _____ Have you quit? Yes ☐ No ☐ 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:*** _____

Blood pressure: _____ / _____ Pulse Ox: _____ Pulse: _____ Temperature: _____

Height: _____ Weight: _____ Medication list completed and attached? Yes ☐

BMI: _____ Within nutritional parameters? Yes ☐ No ☐ Nutritional guidance handout given? Yes ☐

Current smoker? Yes ☐ Smoking cessation handout given? Yes ☐ Mammogram received (within 15 months)? Yes ☐

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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 *(Example: 1x a day / as needed, etc.)*	Route of Administration *(Orally, eye drops, IV, Rectal)*

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

Are you currently undergoing Chemotherapy? Yes ☐ No ☐

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

Please mark any symptoms you are **currently** experiencing

Patient Name:_____ Date:_____

Constitutional
- ☐ appetite
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ rigors/chills
- ☐ weight change

Eyes
- ☐ blurred vision
- ☐ double vision
- ☐ photophobia (extreme sensitivity to light)

ENMT
- ☐ dysphagia
- ☐ ear pain
- ☐ esophagitis (inflammation of the esophagus)
- ☐ hearing ability
- ☐ mouth dryness
- ☐ sinusitis (inflammation of the sinuses)
- ☐ stomatitis (inflammation of the mucous membrane of the mouth)
- ☐ taste altered
- ☐ tinnitus (ringing or buzzing in the ears)

Neck
- ☐ masses
- ☐ pain
- ☐ swelling

Integumentary
- ☐ alopecia (baldness; partial or complete absence of hair where it normally grows)
- ☐ blisters
- ☐ dry skin
- ☐ pruritus (severe itching of the skin)

Breast
- ☐ breast masses
- ☐ nipple discharge
- ☐ pain

Cardiovascular
- ☐ chest pain
- ☐ dyspnea (shortness of breath with exertion)
- ☐ edema (swelling of the arms/legs)

Respiratory
- ☐ cough
- ☐ dyspnea (difficult or labored breathing)
- ☐ hemoptysis (coughing up blood)

Gastrointestinal
- ☐ constipation
- ☐ diarrhea
- ☐ hematemesis (vomiting of blood)
- ☐ hematochezia (fresh blood in bowel movements/stools)
- ☐ nausea
- ☐ pain/cramping
- ☐ vomiting

Genitourinary
- ☐ dysuria (painful or difficult urination)
- ☐ frequency
- ☐ hematuria (blood in urine)
- ☐ incontinence (lack of voluntary control over urination or defecation)
- ☐ nocturia (wake at night one or more times for voiding)
- ☐ sexual function
- ☐ urgency (difficult to delay urination)
- ☐ vaginal discharge/bleeding
- ☐ vaginal spotting

Musculoskeletal
- ☐ arthritis (joint pains)
- ☐ bone pain
- ☐ muscle weakness

Neurologic
- ☐ dizziness
- ☐ gait (trouble walking)
- ☐ headache
- ☐ memory loss
- ☐ neuropathy-motor (weakness)
- ☐ neuropathy-sensory (numbness)
- ☐ seizure

Psychiatric
- ☐ hallucinations
- ☐ depressed mood
- ☐ mania/euphoria mood

Hematologic/Lymphatic
- ☐ easy bleeding
- ☐ lymph node tenderness

- ☐ I am not experiencing any of the above symptoms

COASTAL RADIATION ONCOLOGY MEDICAL GROUP

MISSION HOPE CANCER CENTER

COASTAL RADIATION ONCOLOGY
AT MISSION HOPE CANCER CENTER

Coastal Radiation Oncology
21st Century Oncology Affiliate

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