Pacific Central Coast Health Centers.
A Service of Dignity Health

Patient Demographics

Today's Date________________

Name______________________________________ AKA____________
Last First Middle

DOB______________ Social Security____________________ Sex ☐ Female ☐ Male

Address____

City________________________________ State____ Zip__________

Home Phone (   )______________ Cell Phone (   )______________

Pref. Contact Method______________ Email__________________

Primary Care Physician____________________ Primary Language______________

Race ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Island ☐ White ☐ Other ☐ Decline

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Refuse to Report

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Emergency Contact

Name______________________________ Home Phone (   )__________

Relationship________________________ Work Phone (   )__________

Emergency Contact

Name______________________________ Home Phone (   )__________

Relationship________________________ Work Phone (   )__________

Employer/Student Status ☐ Fulltime ☐ Part-time ☐ Unemployed ☐ Retired ☐ Student ☐ Active Military

Employer__________________________ Work Phone (   )______________

Family and Friends Authorization Persons authorized to receive medical information.

Name__________________________ DOB______________

Name__________________________ DOB______________

Name__________________________ DOB______________

Responsibility for Care (for minors)

☐ Parent ☐ Guardian's Name________________________ DOB__________

Address____

City________________________________ State____ Zip__________

Home Phone (   )______________ Cell Phone (   )______________

Pacific Central Coast
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Annual Patient Acknowledgement

Today's Date________________________

Patient Name____ DOB____________________

Insurance Information Primary Coverage

Insurance Name____________________________________ Subscriber ID ________________________

Subscriber's Name____________________________ DOB______________Relationship to Patient____________

Insurance Information Secondary Coverage

Insurance Name____________________________________ Subscriber ID ________________________

Subscriber's Name____________________________ DOB______________Relationship to Patient____________

Advanced Healthcare Directive

Does patient have a current Advanced Healthcare Directive? ☐ Yes ☐ NO
If no, was Advanced Healthcare Directive information offered to the patient? ☐ Yes ☐ NO

Consent/Authorization

I hereby consent to and authorize all examinations including physical exams, x-ray, and laboratory procedures and obtaining medical histories from pharmaceutical databases that may be necessary in the judgment of the practitioner for diagnostic purposes. I authorize the release of medical or other information necessary to process my insurance claim.

Assignment of Insurance Benefits

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Pacific Central Coast Health Centers (PHC) of any insurance benefits payable to, or on behalf of the patient. It is agreed that payment to PHC, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for the charges not paid pursuant to this agreement.

Financial Policy

- Payment is due for all co-pays, co-insurance, deductibles and non-covered services on the date of service.
- It is your responsibility to know your benefits prior to your visit. Some services and procedures may not be covered by your insurance including preventive care. You are responsible for payment of all non-covered care.
- Amounts due at the time of service are estimates only. Your actual costs may differ.
- Eligibility and benefit confirmation is not a guarantee of payment by your insurance company.
- As a service we will bill all contracted insurance companies for you, however you are responsible for obtaining reimbursement for employer sponsored reimbursement plans.
- Even though you may be covered by medical insurance, you are responsible for the fee. Most insurance companies pay only a portion of the costs.
- For patients who cancel an appointment with less than 24 hours of prior notice or when a patient misses an appointment, a fee of $25.00 may be charged to the patient. This fee is the patient's responsibility to pay, as it is not payable by insurance companies
- I authorize PHC, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and email/text communications. I hereby grant permission and consent to PHC, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection.

By the signature(s) below, I have read, understand, and agree to the Health Care Directive, Consent/Authorization, Assignment of Insurance Benefits and Financial Policy.

________________________________ ________________________________
Patient Name (Please Print) Parent/Guardian Name (Please Print)

________________________ __________ ________________________ __________
Patient Signature Date Parent/Guardian Signature Date

Pacific Central Coast
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Joint Notice of Privacy Practices for Health Information (NPP) Acknowledgment Form

Effective April 14, 2003, the law requires that Dignity Health give to a patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Patient Name: ______________________ Medical Record # ______________________

Acknowledgment Signature: ______________________ Date: ______________________

Print Name: ______________________ Relationship to patient ______________________
(if signed by someone other than patient)

Conjunto Aviso de Prácticas para Información de Salud (NPP) Forma de Reconocimiento

Efectivo el 14 de abril, 2003; la ley requiere que Dignity Health de al paciente una copia de su Aviso de Prácticas de Privacidad para Información de Salud. Le daremos a usted una copia en la hora de su primer tratamiento y, si cambiamos nuestro aviso, de allí en adelante, en su próxima visita. Firmando más abajo, usted como paciente, representante personal del paciente, representante autorizado, o individuo involucrado en el cuidado médico del paciente, reconoce haberlo recibido.

Nombre del paciente: ______________________ # de Récord Médico ______________________

Firma de Recibo: ______________________ Fecha: ______________________

Nombre: ______________________ Relación al paciente: ______________________
(si ha sido firmado por alguien que no sea el paciente)

For Official Use

Signature of Employee: ______________________ Date: ______________________

Print Name: ______________________ Department: ______________________

38610-13 (5/15) NPP

Mission Hope Medical Oncology
New Patient History

Last Name: ______________________ **First Name:** ____________________________ **MI:** ________

Date of Birth: ____/____/______ **Referring physician:** ____________________________________

Please provide the complete name, address and phone number of physicians whom you would like to have informed of your diagnosis, treatment and care.

1.____

2.____

Allergies:

Are you allergic to any medications? ☐Yes ☐No Please list drug and reaction (rash, hives, itching, swelling, etc.)

Drug Name	Reaction	Drug Name	Reaction

Any other allergies? Please list any allergic reactions. ____

____

Past Health History:

What diseases or illnesses have you been **treated or hospitalized** for?

Date	Disease/Illness	Date	Disease/Illness

Have you had a colonoscopy? ☐Yes ☐No **Date of last colonoscopy** ______ / __________
Month Year

Surgical History:

Please list any **surgeries** you have had, including the dates and hospitals:

Date	Procedure/ Hospital	Date	Procedure/ Hospital

Women Only-Reproductive History:

Are you still having menstrual periods? ☐Yes ☐No When did your menstrual periods stop?________

Number of Pregnancies:_______ Number of live births:_________ Number of Miscarriages: __________

Have you ever used hormones ☐**Birth Control** # of years _______☐**Post Menopause** # of years?_____

Date of last **Mammogram:** ____________________ Date of Last **PAP:** _________________________

Date of Last **Bone Density** Study: (For Osteoporosis)________________

Social History:

Do you smoke? ☐Yes ☐No Did you ever smoke? ☐Yes ☐No If yes, when did you quit?____________
How many packs per day do/did you smoke: _______How many years have/did you smoke? ____________

Have you had any exposure to hazardous materials? ☐Yes ☐No List:______________________________

Do you drink alcohol? ☐ Yes **How often? ☐daily ☐once a week ☐socially ☐rarely**

☐No- used to but quit ☐ No-never

Do you use recreational drugs? ☐Yes ☐No If yes, how often? **☐daily ☐occasionally**

Cancer History: Have you been diagnosed with cancer? ☐Yes ☐No
If Yes, what type of cancer: ______________________________Date Diagnosed: ______________
Treatment you have received, if any______________________________Treating Physician:______________

Are you trying alternative methods to control your cancer? ☐Yes ☐No
If yes, please describe:____

Family History:

FATHER: **☐Alive ☐Deceased Age_________Medical Problems**______________________________

MOTHER: **☐Alive ☐Deceased Age_________Medical Problems**______________________________

Do you have any relatives who have had cancer? Please List:

Relationship	Type of Cancer	Age at Diagnosis	Status
☐Father			☐Alive ☐ Deceased
☐Mother			☐Alive ☐ Deceased
☐Brother			☐Alive ☐ Deceased
☐Sister			☐Alive ☐ Deceased
☐Son			☐Alive ☐ Deceased
☐Daughter			☐Alive ☐ Deceased
☐Paternal Grandfather			☐Alive ☐ Deceased
☐Paternal Grandmother			☐Alive ☐ Deceased
☐Maternal Grandfather			☐Alive ☐ Deceased
☐Maternal Grandmother			☐Alive ☐ Deceased
☐Other Relative			☐Alive ☐ Deceased
☐Other Relative			☐Alive ☐ Deceased

Social Demographics:

With whom do you live? ☐ Spouse or Significant Other ☐Family ☐Friend ☐Other ☐Alone

Where do you live? ☐My own home ☐Relative or friend's home ☐Care Facility ☐Other______________

Are you responsible for the care of someone else? ☐Yes ☐No If yes, then whom?______________
If you are in need of help at home, who will be available to assist you? ______________________

What is your highest level of education? ☐ grade school ☐ high school ☐ some college ☐ college degree

Are you employed? ☐Yes ☐No What is your occupation? ______________________________

Disabled? ☐Yes ☐No Retired? ☐Yes ☐No

Do you have children? ☐Yes ☐No

Activities:

Do you exercise?

☐ **Regularly** ☐ **Occasionally** ☐ **Never** What type of exercise?____________________

Do you take nutritional supplements? ☐**Yes** ☐**No** Please list: ______________________________

Medical History

Please mark any that apply:

Problem	Date
☐Anemia	
☐Anxiety	
☐Asthma	
☐Arthritis	
☐Atrial Fibrillation	
☐Bleeding Problems	
☐Blood Disorders	
☐Blood Clots	
☐Blood in Stool	
☐Bone Pain	
☐Bowel Problems	
☐Benign Prostatic Hypertrophy	
☐Cancer	
☐Cardiovascular disease	
☐COPD	
☐Colitis	
☐Cough	
☐Coughing up Blood	
☐Congestive Heart Failure	
☐Constipation	
☐Chest Pain	
☐Coronary Artery Disease	
☐Depression	
☐Diabetes ☐**Type I** ☐**Type II**	
☐Diverticulitis	
☐Diverticulosis	
☐Diarrhea	
☐Difficulty swallowing	
☐Emphysema	
☐Frequent/Painful Urination	
☐Fibrocystic Breasts	
☐Gallstones	
☐Gastro esophageal Reflux	
☐Glaucoma	
☐Headaches	

Problem	Date
☐Heart Attack	
☐Heart Disease	
☐Heartburn	
☐Hepatitis A	
☐Hepatitis B	
☐Hepatitis C	
☐Hypercholesterolemia	
☐Hyperlipidemia	
☐Hypertension	
☐Hyperthyroid	
☐Hypothyroid	
☐Incontinence	
☐Joint Pain	
☐Kidney Stones	
☐Kidney Problems	
☐Liver Problems	
☐Lupus	
☐Melanoma	
☐Nausea/Vomiting	
☐Obesity	
☐Osteopenia	
☐Osteoarthritis	
☐Osteoporosis	
☐Peripheral Neuropathy	
☐Peripheral Vascular Disease	
☐Pneumonia	
☐Rheumatoid Arthritis	
☐Shortness of Breath	
☐Stroke	
☐Seizure	
☐Thrombocytosis	
☐Thalassemia	
☐Thyroid Problems	
☐Uterine Fibroids	

☐Other Not Listed ______________________________________

Mission Hope Medical Oncology.
Patient Medication List

PATIENT NAME: ______________________________ Birth Date: __________________

Today's Date: ________________________________

Are you allergic to any medications? ☐ YES ☐ NO

Medication Allergy	Describe Reaction
______________________	______________________________________
______________________	______________________________________
______________________	______________________________________

Please list all current medications:

Name and dosage	Prescribing Doctor	How Taken
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
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______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other
______________________	__________________	☐once daily ☐2xday ☐as needed ☐other