Dignity Health
Pacific Central Coast
Health Centers

MISSION HOPE CANCER CENTER

1325 E. Church Street, Ste. 202
Santa Maria, California 93454
805.346.3456 Phone
805.346.3454 Fax
missionhopecancercenter.com

Mission Hope Cancer Center
Mission Hope Surgical Oncology Program

Welcome to Our Office
We have scheduled an Appointment for you on:

Date:_____at_____AM/PM

PLEASE ARRIVE 20 MINUTES EARLY FOR YOUR APPOINTMENT

We hope that your visit with us is a pleasant experience. If issues or questions arise on or before your appointment, please call us at **805-346-3456**. Please complete the attached documentation and bring with you on the day of your appointment. Also remember to bring a picture ID, your insurance card and your current medication list.

This appointment is a CONSULTATION ONLY, minor procedures in office are determinded at the time of your visit.

Please Note
Out of respect for all of our patients we try to keep our schedules on time. Therefore, if you arrive more than 15 minutes late or do not have your new patient paperwork completed, your appointment may be rescheduled to another day. Thank you for your cooperation.

Patient Information (aIDX)

Today's Date_____

Last Name_____ First Name_____

Middle Name_____ Title_____ Suffix: ☐ Jr ☐ Sr ☐ II ☐ III ☐_____

AKA_____

DOB_____ Sex: ☐ Female ☐ Male Legal Gender: ☐ Female ☐ Male ☐ Non-Binary

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Life Partner ☐ Widowed

Employment Status: ☐ Full Time ☐ Part-time ☐ Retired ☐ Disabled ☐ Active Military ☐ Retired ☐ Military ☐ Student ☐ Unemployed

Employer's Name_____

Employer's Address_____

Employer's City, State, Zip_____

Employer's Phone_____

Date of Retirement_____

Mailing Address_____

City, State, Zip_____

Email_____

Primary Phone_____ ☐ Cell ☐ Main ☐ Other ☐ Work

Secondary Phone_____ ☐ Cell ☐ Main ☐ Other ☐ Work

Continued on next page.

Patient Relation to Guarantor: ☐ Self ☐ Dependent Child

Guarantor, responsibility of care for minors: ☐ Parent ☐ Guardian

Name_____

Address_____

City, State, Zip_____

Phone_____

Patient Needs: ☐ Ambulates with Assisted Device ☐ Cognitive Disability ☐ Hearing Impaired
☐ Interpreter ☐ Refugee ☐ Sight Impaired ☐ Speech Impaired ☐ Transportation Needs ☐ Wheelchair

Ethnicity: ☐ Hispanic, Latino or Spanish Origin ☐ Not Hispanic, Latino or Spanish Origin ☐ Decline

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Island
☐ Other ☐ Decline

Language_____

Communication Opt Out:
☐ Billing Cell Calls – Patient cell phone will not display on billing documents.
☐ Reminder/Appt. Calls – Patient will not receive appointment reminder calls.
☐ Reminder/Appt. Text – Patient will not receive appointment reminder texts.
☐ Patient Survey – Patient will not receive patient survey.
☐ Future Marketing Mail – Patient will not receive mailers from Marketing Dept.

Primary Care Provider_____
First Name Last Name

Emergency Contact Name_____Relationship_____

Primary Phone_____

Secondary Phone_____

Emergency Contact Name_____Relationship_____

Primary Phone_____

Secondary Phone_____

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. Some treatment or services may be provided through telemedicine. I authorize the release of medical or other information necessary to process my insurance claim.

Participation of Residents and Health Care Students
We may participate in programs to teach resident doctors, medical students, student nurses, and/or other health care students. These persons may observe or participate in the Patient's care under the supervision of doctors, nurses and other professionals.

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

Dignity Health.
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Joint Notice of Privacy Practices for Health Information (NPP)
Acknowledgement Form

The law requires that this facility give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this 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: _____

If signed by anyone other than the patient, please indicate relationship:

Print Name: _____ Relationship: _____

FOR OFFICIAL USE:

I provided a copy of the NPP to the patient/patients representative but was unable to obtain his/her written acknowledgement of receipt of such for the following reasons:

_____

_____

I have attempted to provide to the patient/patients representative a copy of the NPP, but was unable to do so for the following reasons:

_____

_____

Signature of Hospital Representative: _____ Date: _____

Print Name: _____ Department: _____

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Welcome to the Dignity Health Mission Hope Breast Center.
Please take a few minutes to fill out this information, so that your visit may be more streamlined.

Name:_____ **Date of Birth:**_____

Reason for today's visit in your own words: _____
Primary care physician and contact information: _____

Past Medical History:
Please mark any personal or family history of the following medial problems:

	Patient	Family
High Blood Pressure		
Stroke		
Heart Attack		
Hepatitis		
Heart Valve Problems		
Diabetes (Type 1 or Type 2)		
Bleeding Problems		
Clotting Problems		
Heart Disease		
Tuberculosis		
Emphysema/COPD		
Breast Cancer		
Ovarian Cancer		
Kidney Disease		
Peptic Ulcer		
Pneumonia		
Problems with Anesthesia		
Other Cancers		
Other Major Medical Issues		
Ashkenazi Jewish heritage		

Mother medical issues:
_____
_____
_____

Father medical issues:
_____
_____
_____

Siblings medical issues:
_____
_____
_____

Grandparents medical issues:
_____
_____
_____

Any prior breast biopsies or surgery? _____
_____

Other medical history comments: _____
_____

Marital Status: Single Married Widowed Divorced
Who do you live with? _____

Smoking history: _____ packs per day for _____ years
Alcohol history: _____ drinks per day / week / month / year

Age at first period: _____ Age at menopause: _____
Number of pregnancies: _____ Number of children: _____
Age at first birth: _____ Did you breast feed? _____
Birth control pill use: _____ years Hormone replacement therapy: _____ years

Allergies:_____

Past Surgical History:
Please list all prior operations and the approximate year or age at which they were done.

_____

_____

_____

Review of Symptoms: Please mark all that apply.

General:
Unexpected weight change _____
Headaches _____
Sinus problems _____
Nose bleeds _____

Eyes:
Glasses / contacts _____
Eye pain _____
Visual changes _____

Mouth:
Dentures _____
Mouth sores _____
Bleeding gums _____
Other _____

Neck:
Swelling _____
Lumps _____
Other _____

Gastrointestinal:
Appetite change _____
Swallowing difficulty _____
Nausea _____
Heartburn _____
Diarrhea _____
Constipation _____

Neurological:
Seizures _____
Tremors _____
Neuropathy _____

Psychiatric:
Depression _____
Anxiety _____
Other _____

Pulmonary:
Wheezing _____
Shortness of breath _____
Cough _____
Other _____

Cardiovascular:
Chest pain _____
Palpitations _____
Leg swelling _____

Breast:
Pain _____
Nipple discharge _____
New / changed lump _____
Skin change _____

Urinary:
Burning / pain _____
Urgency _____
Frequency _____
Incontinence _____

Musculoskeletal:
Arthritis _____
Weakness _____
Back pain _____
Neck pain _____
Movement limitation _____
Other _____

Skin:
Rash _____
Itching _____
Infection _____

Hematologic:
Bleeding _____
Clotting _____
Anticoagulant meds _____

Is there anything else you would like for us to know today? _____

_____

_____

Patient Signature:_____ Date:_____

Reviewed by:_____ Date:_____