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.
Pacific Central Coast
Health Centers

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: _____

MEDICAL HISTORY - Dr. Jonathan Tammela

1325 East Church Street, Suite 202, Santa Maria, CA 93454
PH (805) 346-3456
Fax (805) 346-3454

DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

Medical Reason for visit: _____

_____

_____

_____

_____

Medical History (Please fill in the bubble next to YES for all medical illnesses you have had)

alcohol abuse	◯ YES	heart disease	◯ YES
allergies	◯ YES	heart failure	◯ YES
anemia	◯ YES	hemorrhoids	◯ YES
anorexia	◯ YES	hepatitis A	◯ YES
anxiety	◯ YES	hepatitis B	◯ YES
autoimmune disorder	◯ YES	hepatitis C	◯ YES
bipolar	◯ YES	hernia	◯ YES
bladder infection, chronic	◯ YES	high blood pressure	◯ YES
bleeding disorder	◯ YES	high cholesterol	◯ YES
bronchitis	◯ YES	high thyroid	◯ YES
bulemia	◯ YES	incontinence	◯ YES
cancer, breast	◯ YES	infertility	◯ YES
cancer, cervical	◯ YES	irritable bowel syndrome	◯ YES
cancer, colon	◯ YES	kidney disease	◯ YES
cancer, ovarian	◯ YES	kidney infection	◯ YES
cancer, uterus	◯ YES	low thyroid	◯ YES
cirrhosis	◯ YES	macular degeneration	◯ YES
deep vein thrombosis	◯ YES	mental retardation	◯ YES
dementia	◯ YES	migraine headache	◯ YES
depression	◯ YES	obesity	◯ YES
diabetes	◯ YES	osteoarthritis	◯ YES
diverticulitis	◯ YES	osteopenia	◯ YES
diverticulosis	◯ YES	osteoporosis	◯ YES
drug abuse	◯ YES	pancreatitis	◯ YES
emphysema	◯ YES	pulmonary embolism	◯ YES
fatigue,chronic	◯ YES	reflux disease	◯ YES
fibromyalgia	◯ YES	schizophrenia	◯ YES
gallstones	◯ YES	seizures	◯ YES
gastritis	◯ YES	sexually transmitted disease	◯ YES
glaucoma	◯ YES	stroke	◯ YES
headache	◯ YES	tuberculosis	◯ YES
heart attack	◯ YES	ulcers	◯ YES

Past Examinations (Please indicate the examinations you have had and the approximate time frame)

Have you ever had an abnormal pap smear? ○ Yes ○ No

If yes, when did you have an abnormal pap smear? ○ <5 yrs ago ○ 5-10 yrs ago ○ >10 yrs ago

Indicate your choleserol level if known: ○ low ○ high ○ normal

If you have had a colonoscopy, how long ago? ○ <5 yrs ago ○ 5-10 yrs ago ○ >10 yrs ago

If you have had a bone density, how long ago? ○ <1 yr ago ○ 1-2 yrs ago ○ >2 yrs ago

Indicate bone density results if known: ○ normal ○ low bone mass ○ osteopenia ○ osteoporosis

Social History (Please fill in the bubble next to the appropriate answer)

Are you:

What birth control method are you using now? ○ pill ○ patch ○ shot ○ IUD ○ condom ○ female sterilization ○ male sterilization

Do you smoke now or have you in the past? ○ Yes ○ No

if yes, how many packs per day ○ <1 pk/day ○ 1-2pks/day ○ >2 pks/day

If you have quit smoking, when did you quit? ○ quit<1 yr ago ○ quit 1-2 yrs ago ○ quit>2 yrs ago

How many years did you/have you?

Do you drink alcohol now or have you in the past? ○ Yes ○ No

If yes, how many alcoholic drinks do you have? ○ 1-2 drinks/day ○ >2 drinks/day ○ 1-2 drinks/wk ○ >1-2 drinks/wk

Do you think you have an alcohol problem? ○ Yes ○ No

Do you use any street drugs now or have you in the past? ○ Yes ○ No

Social History Part 2 (Please fill in the bubble next to the appropriate answer)

Which street durgs have you used?

- ○ marijuana
- ○ cocaine
- ○ methamphetamines
- ○ heroin
- ○ LSD
- ○ crack
- ○ ecstasy

If you have quit using drugs, when did you quit?

- ○ quit<1 yr ago
- ○ quit 1-2 yrs ago
- ○ quit>2 yrs ago

Do you think you have a drug problem?

- ○ Yes
- ○ No

Would you accept a blood transfusion if medically necessary?

- ○ Would accept
- ○ Would not accept

Do you have a living will, advanced directive or durable power of attorney for health care?

- ○ Yes
- ○ No

Family History (Please fill in the bubbles for each family member who has had a listed illness)

	Mother	Father	Grandmother		Grandfather		Siblings	Children
			Maternal	Paternal	Maternal	Paternal		
alcohol abuse	○	○	○	○	○	○	○	○
anorexia	○	○	○	○	○	○	○	○
anxiety	○	○	○	○	○	○	○	○
autoimmune disorder	○	○	○	○	○	○	○	○
bipolar	○	○	○	○	○	○	○	○
bleeding disorder	○	○	○	○	○	○	○	○
bulemia	○	○	○	○	○	○	○	○
cancer, breast	○	○	○	○	○	○	○	○
cancer, cervical	○	○	○	○	○	○	○	○
cancer, colon	○	○	○	○	○	○	○	○
cancer, ovarian	○	○	○	○	○	○	○	○
cancer, uterus	○	○	○	○	○	○	○	○
deep vein thrombosis	○	○	○	○	○	○	○	○
dementia	○	○	○	○	○	○	○	○
depression	○	○	○	○	○	○	○	○
diabetes	○	○	○	○	○	○	○	○
drug abuse	○	○	○	○	○	○	○	○
heart attack	○	○	○	○	○	○	○	○
heart disease	○	○	○	○	○	○	○	○
heart failure	○	○	○	○	○	○	○	○
high blood pressure	○	○	○	○	○	○	○	○
high cholesterol	○	○	○	○	○	○	○	○
high thyroid	○	○	○	○	○	○	○	○
kidney disease	○	○	○	○	○	○	○	○
low thyroid	○	○	○	○	○	○	○	○
mental retardation	○	○	○	○	○	○	○	○
obesity	○	○	○	○	○	○	○	○
osteoarthritis	○	○	○	○	○	○	○	○
osteopenia	○	○	○	○	○	○	○	○
osteoporosis	○	○	○	○	○	○	○	○
pulmonary embolism	○	○	○	○	○	○	○	○
schizophrenia	○	○	○	○	○	○	○	○
seizures	○	○	○	○	○	○	○	○
stroke	○	○	○	○	○	○	○	○

Review of Systems (Fill in the bubble Yes or No for ALL problems you are experiencing CURENTLY)

anxiety	○ Yes	○ No	blood in urine	○ Yes	○ No
depression	○ Yes	○ No	burning w/urination	○ Yes	○ No
			frequent urination	○ Yes	○ No
fatigue	○ Yes	○ No	incontinence	○ Yes	○ No
headache	○ Yes	○ No	night time urination	○ Yes	○ No
fever	○ Yes	○ No	breast lump	○ Yes	○ No
night sweats	○ Yes	○ No	breast pain	○ Yes	○ No
weight gain	○ Yes	○ No	genital sores	○ Yes	○ No
weight loss	○ Yes	○ No	painful intercourse	○ Yes	○ No
			pelvic pain	○ Yes	○ No
rash	○ Yes	○ No	vaginal discharge	○ Yes	○ No
	○	○			
cough, chronic	○ Yes	○ No	abdominal pain	○ Yes	○ No
			black stool	○ Yes	○ No
shortness of breath	○ Yes	○ No	blood in stool	○ Yes	○ No
chest pain	○ Yes	○ No	constipation	○ Yes	○ No
palpitations	○ Yes	○ No	heartburn	○ Yes	○ No
			nausea	○ Yes	○ No
			vomiting	○ Yes	○ No

Medications (Please fill in as completely as possible. Include prescriptions, birth control pills, over the counter pain medications, vitamins and herbs)

Medication	Dosage	Frequency	Reason

Allergies or Adverse Reactions (Please fill in as completely as possible. Include prescriptions, birth control pills, over the counter pain medications, vitamins and herbs)

Medication	**Reaction**

GYN History

How old were you when you period started? _____ How often are your periods? _____

How long do your periods last? _____ What was the first day of your last period? _____

Do you have any bleeding or spotting between periods? _____ Do you have any bleeding or spotting after intercourse? _____

Do you have problems with your periods? _____ Do you have any significant pain with periods? _____

Do you use any medications to relieve the pain? _____ Do you have other pelivic or abdominal pain any other times? _____

If you have gone through menopause, how old were you? _____

Obstetrical History **(How many children have you delivered?_____Please list below)**

Year	Weeks Gestation	Sex	Birth weight	Type of Delivery	Time in Labor	Compications

Do you have any foster, adopted or stepchildren? Any miscarriages, abortions or tubal pregnancies?

(Circle and indicate number of each)

Surgeries and Hospitalizations **(Please do not include childbirth)**

Year	Operation	Hospital	Surgeon

Any Family History Not Previously Listed? **(Please list)**

Any other problems or concerns? **(Please list)**

Patient Signature: _____ **Date:** _____