SLO Oncology & Hematology
715 Tank Farm Road
San Luis Obispo, CA 93401

New Patient Registration Form

Please answer all questions to the best of your ability and as honestly as possible. You can type directly on this form (or print it out and write on it). This information is for the sole use of our practice and will be kept confidential in accordance with all laws and regulations. Forms can be faxed or mailed to our office or brought with you at the time of your first visit. Thank you.

Today's Date: _____

New Patient Information:

Patient Name: _____

Age: _____ **Date of Birth:** ___-___-_____

Social Security Number: ___ ___ ___- ___ ___ - ___ ___ ___ ____

Sex: _____ **Marital Status:** Single Married Widowed Divorced

Home Address: _____

City: _____State: _____Zip Code: _____

Home Phone: (___)_____ **Cell Phone:** (___)_____

Preferred Contact Number: (__)_____

Employer: _____ **Work Phone: (** __)_____

Email Address: _____

Spouse/Significant Other: _____

Spouse/Significant Other Phone: _____

Emergency Contact: _____ **Phone:** _____

Insurance Information:

Primary: _____ **Policy Holder:** Self Spouse Child Other _____

Secondary: _____ **Policy Holder:** Self Spouse Child Other_____

Financial Responsibility: (IF DIFFERENT FROM PATIENT) Name:_____

Notice of Privacy Practices

SLO Oncology & Hematology is committed to protecting your privacy and ensuring that your medical information is used appropriately. This notice of privacy practices identifies all potential uses and disclosures of your health information by our practices and outlines your rights with regards to your health information.

I, _____, acknowledge that I have read and understand the Notice of Privacy Practices of SLO Oncology & Hematology, I understand that a copy of the Privacy Practices can be made available to me at my request.

I consent to have my health information sent to my Primary Care Physician, my Referring Physician, and/or any physician who is actively involved with my care.

Signature: _____ **Date**:_____

Name of Person Representative: (if appropriate):_____

Aside from doctors, please list any family/friends that we CAN release information to:

(We will not share to anyone not on the list, unless we have your consent)

_____

Name **Relationship** **Phone**

_____

Name **Relationship** **Phone**

_____

Name **Relationship** **Phone**

Please list your other physicians or practitioners involved in your care (Primary doctors, Dermatologist, chiropractors, etc.):

_____

Name **Specialty** **Phone**

_____

Name **Specialty** **Phone**

_____

Name **Specialty** **Phone**

Advanced Directives Questionnaire

Please answer the following questions if you are able to do so. The nursing staff will provide assistance if necessary.

Name: _____ Date: _____

1. Do you have a

   Durable Power of Attorney for Health Care? Yes___ No___

   Living Will? Yes___ No___

2. If "yes" to either of the above, please provide us with a copy for your chart.

3. If "no", would you like more information? Yes___ No___

Signature:_____ Date:_____

Financial Waiver

I, _____, authorize treatment and agree to pay all fees and charges for such treatment. Since State Law requires insurance companies to pay claims within 30 days of submission, any claim to an insurance company for which the doctor is a provider that is not paid in 60 days will become my responsibility.

I herby authorize SLO Oncology & Hematology to release information necessary in order to secure payment for services. I assign insurance benefits directly to the above named provider. There is a minimum charge of $25.00 for any forms completed by the provider for the purpose of securing payment.

There is a minimum charge of $15.00 plus 0.25 per page to copy medical records in excess of five pages.

There is a minimum change of $10.00 for any forms completed by the provider that is not directly associated to the care we provide (ie. Letters, disability forms, etc.) This fee may be more depending on the complexity and the extensiveness of the forms. There is a minimum charge of $5.00 for all DMV forms.

For patients <u>NOT</u> on Medicare: I understand that past due accounts (over 30 days) will accrue a monthly finance charge of 1%

Cancellation of an appointment

If it is necessary to cancel your appointment, we require that you call at least 24 hours in advance. Late cancellations will be considered as a “no show”.

The first time there is a “no show”, there will be no charge to the patient. Any additional “no show” will result in a fee of $25.00 billed to patients account.

To cancel appointments, please call (805) 543-5577. If you do not reach the receptionist you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

Signature: _____ **Date:** _____

Name of Personal Representative (if appropriate):

_____ **Date**: _____

New Patient Questionnaire

Name: _____ DOB: ___ ___ - ___ ___ - ___ ___

Is there another name you prefer to be called: _____

Chief Complaint/Main Diagnosis:

What is the main reason for today's visit?_____

Regarding your main problem:

When did your illness start?_____
What were your initial symptoms?_____
What tests were done and where?_____
How have you been treated for this and with what medications?_____

Past Medical History

(Please circle any illnesses or medical problems you have now or have had in the past and indicate the year each started)

ILLNESS	YEAR	ILLNESS	YEAR	ILLNESS	YEAR
Pneumonia		Heart Arrhythmia		Congestive Heart Failure	
Kidney Disease		High Blood Pressure		Liver Disease	
Thyroid Disease		Blood Disorder		Diabetes	
Neurologic Disorders		Stroke		Anxiety/ Depression	
Skin Disease		Cancer		Heart Disease	
COPD		Type of Cancer?			

Please list all major surgeries:

Surgery **Year**

_____

_____

_____

Have there been any recent studies (labs, xrays, ct scans, MRI, ect.) done? If so, where?

_____

_____

What lab facility do you use the most?_____

Name **Location**

Family History

How many siblings do you have? _____ How many children do you have?_____

Do you have relatives with cancer? If Yes…at what age was the diagnosis?(Please list their relationship and type of cancer) _____

Do you have relatives with blood disorders? If Yes…at what age was the diagnosis? (Anemia/Bleeding/Clotting)_____

Social History

Do you currently smoke? Yes No If yes, for how long? _____

Have you ever smoked? Yes No If yes, for how long? _____

Do you currently use alcohol? Yes No If yes, how much and how often?_____

Have you ever used alcohol? Yes No If yes for how long?_____

Do you currently use IV drugs? Yes No If yes, what do you use?_____

Have you ever used IV Drugs? Yes No If yes, what did you use?_____

Any other illegal drugs? Yes No If yes, what?_____

Employer: _____ Job Duties: _____

If retired what was your career _____

In order to facilitate schedule any diagnostic tests please check the following that apply:

	YES	NO	COMMENTS
Allergic to Iodine			
Dialysis			
Diabetic			
Pace Maker			
Blood Thinners			Medication:
Metal in Body			
Implants			
Claustrophobic:			
Previous back surgery:			When/Where:
Previous PET Scan:			When/Where:
Previous Mammogram:			When/Where:

What facility would you like to use for Radiology/Imaging tests?_____

Current Medications and Allergies

Name:_____ **DOB:**___ ___- ___ ___ - ___ ___

Pharmacy: _____ **Phone:**_____
Name **Location**

Allergies

Allergy	Reaction
Example: Penicillin	Breathing difficulties

Medications

Medication	Strength	Frequency	Purpose	Prescribing Doctor
Example: Levaquin	500mg	2 per day		Dr. Sample Smith

Review of Symptoms

Please mark with an (X) any illnesses or medical problems you have, or have had, **within the past year**

Chills		
Night Sweats		
Hot Flashes		
Fatigue/Tiredness		
Estimated Height/Weight_____		
Have you lost weight ____ /gained weight_____		
How much?_____		
Heent		
Headaches		
Dizziness/Vertigo		
Vision Problems		
Hearing Problems		
Nose Bleeds		
Mouth pain/sores		
Dental Problems		
Swallowing Difficulty		
Sore Throat		
Hoarsness		
Other		
Urinary		
Pain with urination		
Difficulty starting		
Urination		
Frequent Urination		
Blood in Urine		
Incontinence		
Other		
Neurological		
Seizures		
Localized weakness		
Numbness		
Numbness in hands		
Numbness in feet		
Difficulty speaking		
Difficulty w/ Memory		
Other		
Skin		
Rash		
Changes in hair		
Changes in nails		
Other		

Shortness of Breath		
Phlegm Production		
Coughing up blood		
Other		
Neck/Back		
Pain (describe)		
Swelling		
Other		
Cardiac		
Heart disease		
Chest pain/angina		
Abnormal heart beat		
High Blood Pressure		
Other		
Gastrointestinal		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Acid Reflux		
Abdominal Pain		
Abdominal Distention		
Bloating		
Dark Stools		
Blood in Stool		
Incontinence		
Other		
Extremities		
Swelling of arms		
Swelling of legs		
Pain in arms/legs		
Pain in joints		
Other		
Psychiatric		
Depression		
Anxiety		
Insomnia		
Other		