

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

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

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 hereby 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 charge 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 NOT 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				Shortness of Breath		
Night Sweats				Phlegm Production		
Hot Flashes				Coughing up blood		
Fatigue/Tiredness				Other		
Estimated Height/Weight _____						
Have you lost weight ____/gained weight ____				Neck/Back		
How much? _____				Pain (describe)		
Heent				Swelling		
Headaches				Other		
Dizziness/Vertigo				Cardiac		
Vision Problems				Heart disease		
Hearing Problems				Chest pain/angina		
Nose Bleeds				Abnormal heart beat		
Mouth pain/sores				High Blood Pressure		
Dental Problems				Other		
Swallowing Difficulty				Gastrointestinal		
Sore Throat				Nausea		
Hoarsness				Vomiting		
Other				Diarrhea		
Urinary				Constipation		
Pain with urination				Acid Reflux		
Difficulty starting				Abdominal Pain		
Urination				Abdominal Distention		
Frequent Urination				Bloating		
Blood in Urine				Dark Stools		
Incontinence				Blood in Stool		
Other				Incontinence		
Neurological				Other		
Seizures				Extremities		
Localized weakness				Swelling of arms		
Numbness				Swelling of legs		
Numbness in hands				Pain in arms/legs		
Numbness in feet				Pain in joints		
Difficulty speaking				Other		
Difficulty w/ Memory				Psychiatric		
Other				Depression		
Skin				Anxiety		
Rash				Insomnia		
Changes in hair				Other		
Changes in nails						
Other						