RADIANT CANCER CARE

NEW PATIENT REGISTRATION PACKET

Date: _____

Last Name: _____ First Name: _____

Nickname: _____ DOB: _____ Sex: _____

SSN: _____ Address: _____

Apt/Suite#: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

E-mail: _____ Mobile: _____

Primary Provider: _____ Referring Provider _____

Employer: _____ Work Phone: _____

Marital Status: _____ Spouse Name & Contact Number:

Alternate Address: _____ Apt/Suite#: _____

City: _____ State: _____ Zip: _____

Insurance Information:

Primary: _____ Plan ID: _____

Group#: _____ Phone Number: _____

Policy Holder: _____ Policy Holder DOB: _____

Secondary: _____ Plan ID: _____

Group#: _____ Phone Number: _____

Policy Holder: _____ Policy holder DOB: _____

Guarantor: _____ Guarantor Relationship: _____

Emergency Contact Information:

Name: _____ Phone: _____

Relationship: _____ Guardian: _____

Address: _____ Apt/Suite#: _____

City: State: Zip:

Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?

☐ Yes ☐ No If yes, please fill out the following:

Facility Name: _____ Phone: _____

Address: _____

What language do you feel most comfortable using when discussing your healthcare?

_____

How did you hear about us?

☐ Physician Referral	☐ Family or Friend	☐ Insurance Referral	☐ Hospital
☐Integrative Oncology Essentials	☐ Communications Forum (Seminar, etc)	☐ Media (newspaper, magazine, billboard, radio, TV)	
☐ Internet (website, search engine, Facebook, etc.)		☐ No Response	

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ALLERGIES:

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If yes, list all the medications and the reactions:

_____

_____

Other allergies (drug, food, tape etc.) _____

I. CURRENT MEDICATIONS:

Medication	Dose	Frequency

Pharmacy Name: _____ **Pharmacy Address:** _____

II. RADIATION THERAPY, CHEMOTHERAPY, AND HORMONE THERAPY HISTORY:

Have you ever received radiation therapy: ☐ Yes ☐ No If yes, When? _____

What part of the body/area was treated? _____

III. PAST MEDICAL HISTORY Check all that apply.

☐ Cancer diagnosis, if so, what type of cancer? _____

☐ Heart Disease / CAD	☐ Emphysema	☐ Diabetes Implanted Insulin pump? **Yes or No**	
☐ Heart attack	☐ COPD	☐ Thyroid disorder	
☐ Congestive heart failure	☐ Pneumonia	☐ Kidney disease	
☐ Atrial fibrillation	☐ Chronic bronchitis	☐ Liver disease	
☐ High cholesterol	☐ Asthma	☐ HIV	
☐ Hypertension	☐ Stroke	☐ Anemia	☐ Other

IV. DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? Check all that apply.

CONSTITUTIONAL:
☐ Fever/chills
☐ Increased fatigue
☐ Night sweats
☐ Unexplained weight loss
If so, how much? _____
☐ Weight gain
If so, how much? _____
Current height: _____
Current weight: _____

EYES/EARS/NOSE/THROAT
☐ Cataracts
☐ Glaucoma
☐ Diminished Eyesight
☐ Experienced hearing loss
☐ Sinus problems
☐ Hoarseness
☐ Dentures

CARDIAC:
☐ Angina (chest pain)
☐ Irregular heartbeat

PULMONARY:
☐ Persistent cough
☐ Coughing up blood
☐ Shortness of breath
☐ Inability to lie flat
☐ Positive TB test
Influenza vaccine ☐ Yes ☐ No
Date: _____
Pneumonia vaccine ☐ Yes ☐ No
Date: _____
COVID-19 vaccine ☐ Yes ☐ No
Date: _____

GASTROINTESTINAL:
☐ Difficulty swallowing
☐ Decreased appetite
☐ Frequent vomiting
☐ Hiatal hernia
☐ Gastric reflux
☐ Bowel polyps
☐ Dark/black stool
☐ Diverticulosis
☐ Diverticulitis
☐ Blood in stool
☐ Frequent diarrhea
☐ Inflammatory bowel disease (Ulcerative colitis/ Crohn's)
☐ Constipation
☐ Hemorrhoids Colonoscopy/sigmoidoscopy
☐ Yes ☐ No
Date: _____

GENITOURINARY:
☐ Difficulty starting stream
☐ Blood in urine
☐ Pain or burning on urination
☐ Frequent urination
☐ Getting up at night to urinate
☐ Urinary urgency
☐ Leakage of urine
☐ Kidney stone
☐ Elevated PSA
☐ Urinary Tract Infections
☐ Difficulty with Erections
Are you sexually active?
☐ Yes ☐ No

NEUROLOGICAL:
☐ Frequent headaches
☐ Dizziness/ lightheadedness
☐ Tremors
☐ Paralysis
☐ Numbness
☐ Polio
☐ Weakness in limbs
☐ Seizures

PSYCHIATRIC:
☐ Anxiety
☐ Depression
☐ Psychosis
☐ Bipolar disorder

RHEUMATOLOGICAL:
☐ Systemic lupus erythematosus
☐ Rheumatoid arthritis
☐ Osteoarthritis/arthritis
☐ Scleroderma/CREST syndrome
☐ Gout
☐ Bone pain
☐ Broken bones: _____

V. PAST SURGICAL HISTORY: Please list when (year)

☐ Eye surgery _____
☐ Tonsillectomy_____
☐ Thyroid surgery_____
☐ Heart surgery_____
☐ Coronary artery by-pass_____
☐ Breast surgery_____
☐ Appendectomy_____
☐ Cholecystectomy_____
☐ Hernia surgery_____
☐ Colon or rectal surgery_____

☐ Heart valve replace/repair_____
☐ Coronary artery stent_____
☐ Defibrillator placement_____
☐ Pacemaker placement_____
Type/Mode/Cardiologist:_____
_____
☐ Lung surgery_____

☐ Bladder surgery_____
☐ Prostate surgery_____
☐ Hysterectomy or gynecological surgery _____
☐ D & C_____
☐ Joint replacement_____
☐Other_____

VI. PAIN

Are you in pain now? ☐ Yes ☐ No When did you pain start? _____
On a scale of 1-10 with 10 being the worse pain, how severe is your pain? _____
Location of pain: _____

VII. MOBILITY-FALL RISK ASSESSMENT:

Do you need assistance walking: ☐ Yes ☐ No
If so, do you use any of the following? ☐Cane ☐Walker ☐Wheelchair
Have you fallen before or been injured because of a fall? ☐ Yes ☐ No
How many falls have you had in the past 12 months? _____ Any injuries? _____

VIII. FEMALE: Please complete the following information:

When did you start having menstrual periods? Age/Year of 1st Period: _____
Are you currently having menstrual periods? Yes____ No _____ Last Period: _____
Are you now, or is there a chance, you might be pregnant? Yes _____ No _____
Number of pregnancies: _____ Number of deliveries: _____ Your age when first child born: _____
Did you breast feed any of your children? Yes____ No _____
Did you ever take hormones (i.e. Estrogens, birth control pills, androgens)? Yes____ No _____
If yes, for how long? _____ Prescribing physician: _____
Bra cup size: _____ Nipple discharge? Yes _____ No _____

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IX. WE SCREEN ALL PATIENTS FOR DOMESTIC VIOLENCE OR ABUSE:

Does anyone at home hurt, hit or threaten you? ☐ Yes ☐ No
If yes, explain: _____

X. SOCIAL GEOGRAPHIC HISTORY:

In which state (or country) were you born? _____
In what area did you live most of your life?_____
How long have you lived in your current state of residence? _____
Do you live in this state all year round? ☐ Yes ☐ No
If no, what is your alternate address and phone number? _____
_____

XI. SOCIAL HISTORY:

Have you ever smoked? ☐ Yes ☐ No How long? _____ How many packs a day? _____
Have you quit smoking? ☐ Yes ☐ No If yes, when? _____
Have you ever chewed tobacco? ☐ Yes ☐ No How much? _____
Have you ever quit chewing tobacco? ☐ Yes ☐ No If yes, when? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____
Have you quit drinking? ☐ Yes ☐ No If yes, when did you quit? _____
Do you use any street drugs? ☐ Yes ☐ No
If so, which street drugs? ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Other: _____
Do you need any help with any of the following: coping, financial assistance, nutrition, social work, transportation, home assistance? ☐ Yes ☐ No Please explain: _____
Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed
Do you have a strong social support system ☐ Yes ☐ No If so, who? _____
Do you adhere to any religious beliefs that you would like us to know about? _____
Are you still working? ☐ Yes ☐ No If no, explain: _____
What is/was your primary occupation? _____
Have you served in the military? ☐ Yes ☐ No If so, which branch of military? _____

Did you ever work in an occupation that involved exposure to asbestos or any other cancerous chemicals, fumes, or carcinogens? ☐ Yes ☐ No Please explain: _____

XII. FAMILY HISTORY OF CANCER OR BLOOD DISEASES:

Father: If living, age _____ If deceased, age of death_____
Any history of cancer? _____ Type: _____
Mother: If living, age_____ If deceased, age of death_____
Any history of cancer? _____Type:_____
Siblings: How many sisters? _____ How many brothers?_____
Any history of cancer? _____Type:_____
Children: How many daughters? _____ How many sons?_____
Any history of cancer? _____Type:_____
Is there any history of cancer of blood diseases in other family members such as grandparents, aunts, uncles, cousins, etc.? ☐ Yes ☐ No If yes, Please explain: _____

XIII. PLEASE LIST THE NAMES AND ADDRESSES OF PHYSICIANS YOU WOULD LIKE CORRESPONDENCE SENT TO

Name	Phone	Fax

Do you have a medical Durable Power of Attorney? ☐ Yes ☐ No

If you answered 'yes' to any of the above questions, please provide a copy of the document.

As the patient, you acknowledge that with the completion of this form, it constitutes your complete clinical history summary.

Patient signature: _____ **Date:** _____

PATIENT CONSENT FOR DISCLOSURE TO INVOLVED INDIVIDUALS

Patient Name: _____ Date of Birth: _____

Our physicians and staff know that communicating with you about your healthcare is important. By completing this form, you give us permission to provide messages, and/or discuss information about your healthcare with the individuals designated below. I understand that I may cancel or update this information at any time by notifying a representative of the physician office.

I give permission to allow physicians and staff to discuss relevant medical, billing, and insurance information with the individuals listed below (examples, spouse, relatives, friend, etc.). I understand that my healthcare provider will use professional judgment to determine what information about my healthcare may be discussed with the designated individuals below*:

Involved Individual	Relationship to Patient	Phone Number

Patient/Authorized Representative Signature*_____ Date_____Time_____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

**If signed by a patient-authorized representative, supporting legal documentation must accompany this authorization form.*

Note: Radiant Cancer Care expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

Assignment Of Benefits/Right to Payment Authorization, Patient Responsibility, And Release of Information Form

Radiant Oncology Medical Group

40055 Bob Hope Drive Suite B

Rancho Mirage, CA 92270

I, the undersigned, assign to the provider/entity referenced above ("Provider"), my rights and benefits in any medical insurance plan, health benefit plan, or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I authorize my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive from my insurance company due for services rendered by the Provider are owed to Provider and I agree to remit those funds directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment/Authorization shall be considered as effective and valid as the original.

_____ _____

Signature of Patient/Person Legally Responsible Date

_____ _____

Print Name of Patient/Person Legally Responsible Date

_____

Relationship to Patient (if signed by Person Legally Responsible)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment:

We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment:

We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:

- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care:

We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research:

We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications:

We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:

- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement/Legal Proceedings:

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Other Uses of Your Protected Health Information That Require Your Authorization

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any lime. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternate means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.radiantcancercare.com.

Changes to This Notice

We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679- 8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge:

A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgement was not obtained:

- ☐ Patient/family member received notice but refused to sign acknowledgment
- ☐ Emergency treatment situation
- ☐ Patient was incapacitated and no family member was present
- ☐ Unable to communicate due to language barriers
- ☐ Other (please describe below)

_____

_____

_____

_____

_____ _____

Signature of Employee Date