Cancer Care Center, PC

Patient Registration Form

Date: ___/___/_____

Patient Information:

(Please print)

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security # : _____

Sex: M / F Marital Status: _____ Spouse's Name: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email Address: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone: _____

Patient Employer Name: _____ Employer Phone: _____

Pharmacy Name & Location: _____

Referring Physician: _____

Reason for Visit: _____

Please provide insurance card(s) to the front desk.

*** Co-payments are due at the time of your visit. In the event of financial hardship, our office will gladly negotiate a payment plan for unpaid balances. ***

Cancer Care Center, PC

Patient Intake Form

Patient Name: _____ Date of Birth: _____

Height:_____ Weight:_____

Physicians:

Primary Care: _____

Surgeon: _____

Other: _____

List all Medications:

	Medication:	Strength:	Directions: (When/ how often do you take the medication?)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

List all Medication Allergies:

Medication:	Reaction to Medication:

Circle all that apply and explain:

Heart Disease	_____	Liver Disease	_____
Diabetes	_____	Kidney Disease	_____
High Blood Pressure	_____	Stroke	_____
Other	_____	Other	_____

Surgeries: (Please provide approximate month & year of surgery)

Surgery	Date	Surgery	Date

Family History:

	Alive/Deceased	Major Medical Problems
Mother		
Father		
Brothers		
Sisters		
Children		

Personal Habits: (circle all that apply)

Tobacco: Non-smoker Smoker ____ packs per day ____ years smoking

Alcohol: Yes No

Chemical or Toxin exposure: Yes No

Disabled: Yes No

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

Symptoms / Problems in the past 6 months: (circle answer)

				Comments
General:	weight loss	yes	no	
	fever	yes	no	
	night sweats	yes	no	
	fatigue	yes	no	
Skin:	rash	yes	no	
	itching	yes	no	
	skin cancer	yes	no	
	skin ulcers	yes	no	
Respiratory-	shortness of breath	yes	no	
cardiovascular:	hoarseness/cough	yes	no	
	wheezing	yes	no	
	irregular heart beat	yes	no	
	ankle swelling	yes	no	
	wake up out of breath	yes	no	
	chest pain	yes	no	
Gastrointestinal:	nausea	yes	no	
	vomiting	yes	no	
	difficulty swallowing	yes	no	
	abdominal pain	yes	no	
	diarrhea/constipation	yes	no	
	blood in stools	yes	no	
Genitourinary:	difficulty urinating	yes	no	
	painful urination	yes	no	
	urinate at night	yes	no	
	blood in urine	yes	no	
	kidney stones	yes	no	
Musculoskeletal:	back pain	yes	no	
	arthritis	yes	no	
	joint swelling	yes	no	
	broken bones	yes	no	
Neurologic:	headaches	yes	no	
	loss of vision	yes	no	
	numbness in hands or feet	yes	no	
	weakness in arm or leg	yes	no	
Endocrine:	unable to tolerate the cold	yes	no	
	loss of sexual interest	yes	no	

Date of last mammogram: _____
Date of last pelvic exam: _____
Date of last colonoscopy: _____
Date of pneumonia vaccine: _____

Cancer Care Center, P.C.
1310 14th Avenue SE
Decatur, AL 35601
Phone: 256-353-5151 Fax: 256-351-9915

Authorization to Pay

I hereby authorize payment of medical and/or emergency medical benefits, including major medical

Signature (patient or authorized party) Date

Medicare Insurance Assignment

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Cancer Care Center, P.C.

Signature (patient or authorized party) Date

Medicaid Insurance Assignment

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the State of Alabama or its fiscal agents any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf to Cancer Care Center, P.C.

Signature (patient or authorized party) Date

Acknowledgement of receipt of Notice of Privacy Practices

I have received a copy and understand the Notice of Privacy Practices for Cancer Care Center, P.C.

Patient's Social Security Number Date of Birth

Signature (patient or authorized party) Date

Witness Date

Cancer Care Center, P.C.
1310 14th Avenue SE
Decatur, AL 35601
Phone: 256-353-5151 Fax: 256-351-9915

Due to recent federal guidelines(HIPAA), Cancer Care Center, P.C. is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit authorization is given to authorize Cancer Care Center, P.C. permission to discuss personal medical information with someone other than yourself, please fill in below.

I, _____ give Cancer Care Center, P.C. permission to release/discuss personal medical information to include the pickup of prescriptions and/or financial information to/with:

Name of Person	Relationship to Patient	Phone Number
Name of Person	Relationship to Patient	Phone Number
Name of Person	Relationship to Patient	Phone Number
Name of Person	Relationship to Patient	Phone Number

I understand that I may revoke this authorization at any time by sending written notification to the Privacy Office at 1310 14th Avenue, Decatur, AL 35601. By signing this form, all previous lists of allowable contacts become invalid.

Signature (patient or authorized party) _____ Date _____

Witness _____ Date _____

I, _____ decline to give Cancer Care Center, P.C. permission to release/discuss personal medical and/or financial information to anyone other than myself.

Signature (patient or authorized party) _____ Date _____

Witness _____ Date _____

Cancer Care Center, P.C.
Dr. Naveen Lobo
1310 14th Avenue SE
Decatur, AL 35601
Phone: 256-353-5151 Fax: 256-351-9915

I, _____, hereby authorize Dr. _____ to release copies of my past medical records to Dr. Naveen Lobo at Cancer Care Center.

Patient Signature: _____

Date: _____

Date of Birth: _____

Witnessed by: _____