Name: _____
DOB: _____

Date: _____

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION: _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

Office: _____ **Date:** _____

Last Name: _____ **First Name:** _____ **M.I**.: _____

SSN: _____ **DOB:** _____ **Sex**: _____

Address: _____ **Apt/Suite #:** _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Mobile Phone:** _____

E-Mail Address: _____

Primary Care Physician: _____

Employer: _____ **Work Phone:** _____

Marital Status: _____ **Is your spouse working or retired?** _____

Spouse Name: _____ **Spouse DOB:** _____

Spouse SSN: _____ **Spouse Contact Number:** _____

ALTERNATE ADDRESS: _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

☐ **I do not have an alternate address Date of Alternate Address to:** _____ **From:** _____

Alternate Address: _____ **Apt/Suite#:** _____

City: _____ **State:** _____ **Zip:** _____

INSURANCE INFORMATION: _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

Primary Insurance: _____ **Plan ID:** _____

Group #: _____ **Phone Number:** _____

Secondary Insurance: _____ **Plan ID:** _____

Group #: _____ **Phone Number:** _____

EMERGENCY CONTACT INFORMATION: _____ **(I HAVE REVIEWED ALL THE INFORMATION BELOW IS ACCURATE)**
PATIENT INITIALS

Name: _____ **Phone**: _____

Relationship to Contact: _____ **Guardian:** _____

Address: _____ **Apt/Suite #:** _____

City: _____ **State**: _____ **Zip**: _____

Name: _____
DOB: _____

Date: _____

NEW PATIENT REGISTRATION FORM

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR RACE?

☐ Asian	☐ Caucasian	☐ Black / African American	☐ Hispanic
☐ Subcontinent Asian American		☐ Asian Pacific American	☐ Native American
☐ American Indian/Alaskan Native		☐ Hawaiian	☐ Pacific Islander
☐ More than one race		☐ Other	☐ Decline

PLEASE SELECT ONE ETHNIC GROUP THAT BEST DESCRIBES YOUR ANCESTRY:

☐ Hispanic or Latino	☐ Non-Hispanic or Latino
☐ Decline	☐ Don't know

WHAT LANGUAGE DO YOU FEEL MOST COMFORTABLE USING WHEN DISCUSSING YOUR HEALTHCARE?

☐ English	☐ Spanish	☐ German	☐ French
☐ Italian	☐ Russian	☐ Portuguese	☐ Chinese
☐ Other	☐ Decline	☐ Don't know	

WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY MAIL, E-MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY?

☐ Yes	☐ No

HOW DID YOU HEAR ABOUT US?

☐ Physician Referral	☐ Family or Friend	☐ Insurance Referral
☐ Internet (website, search engine, Facebook, etc)		☐ Media (newspaper, magazine, billboard, radio, TV)

WHEN CONDUCTING YOUR OWN RESEARCH, HOW OFTEN DO YOU USE THE INTERNET FOR GATHERING INFORMATION?

☐ Always	☐ Usually	☐ Sometimes	☐ Never

Name: _____
DOB: _____

Date: _____

NEW PATIENT REGISTRATION FORM

Reason for Visit: _____
Primary Care Physician: _____
Other physicians involved in your care:_____
_____

Past Medical History NONE _____

Circle the following conditions for which you have been treated or are currently being treated:

AAA (Abdominal Aortic Aneurysm)	CHF/Congestive Heart Failure	Hernia	Pancreatitis
MI/Heart Attack	Colon Cancer	High BloodPressure	Peptic Ulcer
Anemia	COPD	HIV	Pneumonia
Angina	CVA	Hyperlipidemia	Prostate Cancer
Anxiety	Depression	Hypertension	Peripheral Vascular Disease
Arthritis	Diabetes	Hyperthyroid	Renal Disorders
Asthma	Diverticulitis	Hypothyroid	Rheumatoid Arthritis
Bladder Cancer	Eczema	Kidney Disease	Seizure Disorder
Blood Transfusion	Emphysema	Lymphedema	Syncope (Fainting)
BPH/Enlarged Prostate	Esophagitis	Migraines	Thromboembolic Disease
Breast Cancer	Glaucoma	Neuralgia	Urticaria
Carotid Stenosis	Gerd	Neuritis	
CAD/Coronary Artery Disease	Gout	Obesity	
	Head Injury	Osteoarthritis	
	Heart Disease	Osteoporosis	
	Hepatic Disorders		
	Hepatitis		

Other Conditions: _____

Last Colonoscopy (year) _____ Last Mammography (year) _____

Past Surgical History NONE _____

What Operations have you had? (Give approximate year)

Name: _____
DOB: _____

Date: _____

NEW PATIENT REGISTRATION FORM

Current Medication NONE _____

Coumadin/Warfarin/Plavix or other blood thinner _____? Yes No Dose: _____

Preferred Pharmacy: _____ Address: _____
Phone: _____

List all current medications including INHALERS, HERBAL SUPPLEMENTS, OVER THE COUNTER and dosages:

Medication	Dose	Times/Day	Medication	Dose	Time/Day

Allergies NONE _____

List all medications to which you are allergic & your reaction to the medication:

Allergies	Reaction	Allergies	Reaction

Family History	Living	Age	Deceased	Age @ Death	Cause of Death
Mother					
Father					
Brother (s)					
Sister (s)					
Son (s)					
Daughters (s)					

Social History

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed
Occupation: _____ Employer: _____ □ Retired
Employment Type: None / Desk Based / Light Physical / Moderate Physical / Heavy Physical
Tobacco Use: □ Never □ Former Years since quit? ____ □ Yes Years smoked? _____ # packs/day ____
Alcohol Use: Do you drink alcohol? □ Yes □ No Type _____ Drinks per day _____
Drug Use: □ Yes □ No Substance: _____

Name: _____
DOB: _____

Date: _____

NEW PATIENT REGISTRATION FORM

SYSTEM REVIEW

Review of Systems (Check any of the following that apply to you)

Constitutional	**Gastrointestinal**	**Neurological**	**Eyes**
□ Feeling fine □ Weight Loss □Weight gain □ Frequent fevers □ Fatigue/tired	□Loss of appetite □Nausea □Vomiting □Abdominal pain □Heartburn □Change in bowel habits □Regular use of laxatives □Blood in stool	□Headache □Dizziness □Seizure □Tremors □Speech problems □Balance problems □Memory loss	□Sensitivity to light □Vision changes □Wears glasses or contacts
Ears/Nose/Throat	**Genito-urinary**	**Psychological**	**Cardiovascular**
□Hearing loss or ringing □Earache □Ear drainage □Nasal stuffiness □Frequent nosebleeds □Mouth sores □Sore throat □Lump/swelling in neck □Difficulty swallowing	□Frequent urination □Painful urination □Blood in urine □Incontinence □Penile discharge □Testicular pain □Testicular lump □Irregular periods □Vaginal discharge	□Feeling nervous □Sleep disturbances □Depression □Psychological symptoms □ thoughts about suicide	□Low exercise tolerance □Chest pain □Heart attack □Palpitations □Edema/swelling
Musculoskeletal	**Endocrine**	**Hematology**	**Respiratory**
□Joint pain □Joint swelling □Joint stiffness □Weakness □Muscle pain □Back pain	□Night sweats □Excessive thirst □Temperature intolerance	□Easy bruising □Swollen glands □Slow to heal after cuts □Past transfusion	□Shortness of breath □Cough □Coughing up blood □Wheezing
Skin	**Allergic/Immunologic**		
□Rashes □Itching □Non-healing lesions □Breast pain or lumps	□Frequent infections □Chemotherapy □X-ray treatments		

Name: _____
DOB: _____

Date: _____

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

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21ST CENTURY ONCOLOGY - KSF
21st Century Oncology, LLC
Associates in General & Vascular Surgery
PO Box 862152
Orlando, FL 32886-2152

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 by my insurance company due for services rendered by 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)

Name: _____
DOB: _____

Date: _____

Patient Authorization for General Disclosure and/or Request for Restrictions of Protected Health Information and Request for Confidential Communications

I hereby request the following use or disclosure of my health information as described below.

Patient Name:	**Date of Birth:**	**Medical Record Number:**
Address (Street, City, ZIP, Code):		**Telephone Number:**

I requested that my health information or billing record be disclosed or restricted, as follows:

I authorize the names listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case. I have the right to terminate this agreement at any time by informing a representative of the physician office.

Authorized Name	**Relationship to Patient**

***DO NOT** discuss or provide information to the following individuals or entities:

Restricted Name/Entity	**Relationship to Patient**

***I request the use of ONLY the following address and/or phone number(s) to contact me regarding my health or billing information:**

_____ _____

_____ _____

Patient Rights: Your physician office must permit patients to request restrictions of their protected health information. Patients may request restriction of uses and disclosures of protected health information to carry out treatment, payment, and healthcare operations; disclosures to a family member, other relative, close personal friend, or any other person identified by the patient of protected health information directly relevant to such person's involvement with the patient's care; and disclosures of protected health information to notify or assist in the notification of a family member, a personal representative, or another person responsible for the care of the patient of the patient's location, general condition, or death. All requests for restrictions must be submitted in writing.

Physician Office Responsibilities: Your physician office is not required to grant most restrictions and is precluded from granting restrictions that violate the law. If we agree to the restrictions, we will comply with it unless you ask to terminate the restriction or we notify you that we are terminating the agreement. If you require emergency treatment, we may release the restricted information without your consent if it is needed to provide that treatment.

Signature of Patient or Legal Representative	**Date:**

If signed by Legal Representative, Relationship to Patient

THIS SECTION TO BE COMPLETED BY PHYSICIAN OFFICE PERSONNEL ONLY

DISPOSITION of PATIENT REQUEST: The above request for restriction of health information by the above-named patient has been:

☐ ***Granted** _____ | ☐ **Denied** _____

***If GRANTED, an Alert must be entered into all electronic medical records and/or practice management (billing) system(s)**

Reason(s) for Denial, if Applicable: _____

_____

Physician Office Representative:	**Date:**

Name: ______________________________
DOB: ______________________________

Date: _____________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

21st CENTURY ONCOLOGY - KSF

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)

____
____
____
____

Name: _____
DOB: _____

Date: _____