Patient Registration (Please complete ALL Information)

Last Name:_____ **Date:**_____

First Name:_____ **Gender: M / F**

Street Address:_____ **Date of Birth:**_____

Apartment #:_____ **Social Sec. #:**_____

City:_____ **State:** _____ **Zip:**_____ **Home Phone #:**_____

Cell Phone: _____**Work Phone:** _____**Email:**_____

Alternate Address

Street Address:_____ **Apartment:**_____

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

Employer:_____ **Marital Status: M S W D**

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

Spouse SS#:_____

Primary Insurance:_____

Subscriber:_____ **ID#:**_____ **Group #:**_____

Secondary Insurance:_____

Subscriber:_____ **ID#:**_____ **Group #:**_____

Emergency Family Contact Name:_____**Relationship:**_____

Address:_____**Phone:**_____

Who may we thank for referring you to us? _____

Referring Physician:_____ **Phone#:**_____

Primary Care Physician:_____ **Phone #:**_____

Pharmacy Info.:_____ **Phone #:**_____

Use this form during patient registration to document any patient requests to authorize and restrict how their health information is disclosed to friends/family members/others. Use also to document any requests for confidential communications.

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, State, ZIP Code)	Telephone Number

I request that my health information or medical 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 would violate the law. If we agree to the restriction, 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:

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

21st Century Oncology, LLC
Regional Breast Care
PO BOX 86215 ORLANDO, FL 32886-2152

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund 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 instruct 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 will be immediately signed over and sent 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 shall be considered as effective and valid as the original.

_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)

Chart Number:_____

Patient name:_____
Date of birth:_____Age:_____
Chief complaint:_____
History of present illness:_____

Past Medical History:

☐ High Blood Pressure	☐ Asthma/COPD	☐ High Cholesterol
☐ Diabetes	☐ Heart Disease/Afib	☐ Stroke/TIA
☐ Kidney Disease	☐ HIV/AIDS	☐ Depression
☐ Thyroid Disorder	☐ Blood Clots (DVT)	☐ Arthritis
☐ Liver Disease	☐ TB	☐ Hepatitis
☐ Alzheimer Disease	☐ Seizures	☐ Cancer

☐ Others_____

Past surgical history:_____
_____

Alcohol Consumption: YES NO If yes, how much? _____
Tobacco use: YES NO # Years?_____If no longer using, when did you quit?_____
Caffeine Intake: YES NO How many cups/glasses per day? _____
Recreational Drugs: YES NO If yes, type and how long?_____
Any Metal in your body: YES NO If yes, where?_____
Marital status:_____# of children/ages:_____
Occupation:_____

Ethnicity: Caucasian African American Latino Asian
Pacific Islander Native American Ashkenazi Jews Descendant
Other _____

Religious Preference: _____

Family History:

Breast CA	Who:_____	Maternal/Paternal	Age:_____
Ovarian CA	Who:_____	Maternal/Paternal	Age:_____
Prostate CA	Who:_____	Maternal/Paternal	Age:_____
Pancreatic CA	Who:_____	Maternal/Paternal	Age:_____
Colon CA	Who:_____	Maternal/Paternal	Age:_____

Others Types of CA _____

Patient Name:_____ DOB:_____

GYN History: Age of first menstrual period:_____ Last menstrual period: _____
Menopause: _____# of pregnancies: _____
#of live births: _____ age first pregnancy: _____
Did you breast feed: Y N age: _____
Hormone replacements: _____

Breast History:
Infections: YES NO Which Breast: Right Left Both When?_____
Masses: YES NO Which Breast: Right Left Both When?_____
Pain: YES NO Which Breast: Right Left Both When?_____
Biopsy: YES NO Which Breast: Right Left Both When?_____
Nipple Discharge: YES NO Which Breast: Right Left Both Color:_____
When did it start? _____
Fibrocystic disease: YES NO Breast Implants: YES NO
Previous Radiation therapy to the chest: YES NO If yes, please explain_____
_____
Breast Cup size: _____

Allergies:	**Reaction:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Additional:_____

Medications:	**Dosage:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Additional: _____
_____

Patient Name: _____ **DOB**: _____

Review of Systems: (Circle any that apply)

Constitutional: Feeling tired or poorly, chills, fevers, Weight change

Ears/nose/throat: Nasal Congestion, Post nasal drip, Sore throat

GU: pain during urination, increased frequency of urination, blood in urine

GI: Decreased appetite, Abdominal pain, Nausea, Vomiting, Diarrhea, Constipation, Heartburn, Blood in stool

Skin/Musculoskeletal: Rash, Neck pain, Back pain, Joint pain

Chest: Difficulty swallowing, Cough, Shortness of breath, Palpitations, Chest pain or discomfort

Hematologic: Easy bruising tendency, Excessive sweating, sweating heavily at night, Excessive thirst, Temperature intolerance

Gynecological: Unexplained vaginal bleeding, vaginal discharge, vaginal pain, vaginal itching or burning

Neuro/Eyes: Headaches, Dizziness, Ringing in the ears, Numbness, Generalized decreased in strength, Red eyes, Sleep disturbances, Depression, Anxiety

Primary Care Doctor: _____

Other Doctors to copy on Correspondence: _____
_____

21st Century Oncology, LLC
Regional Breast Care

ACKNOWLEDGMENT 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

_____
Print Name

****

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 acknowledgment 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