SOUTH GEORGIA CENTER FOR CANCER CARE | RADIATION ONCOLOGY

PATIENT REGISTRATION

NAME: _____ **TODAY'S DATE**: _____

Last First MI

SS #_____ **SEX:** M_____F_____ **DOB**:____/____/_____ **AGE:** _____

ADDRESS:_____

HOME PHONE ( ) _____ **CELL PHONE ( )** _____ **WORK PHONE ( )** _____

EMAIL ADDRESS_____

MARTIAL STATUS: _____ **SPOUSE'S NAME:** _____ **PHONE** _____

RACE _____ **ETHNICITY** _____ **PRIMARY LANGUAGE** _____

EMPLOYMENT STATUS □ Full time □ Part time □ Retired **OCCUPATION**_____

EMPLOYER NAME_____ **EMPLOYER PHONE ( )** _____

PRIMARY HEALTH INSURANCE **Primary Subscriber's SS# (if different than patient)** _____/_____/_____

INSURANCE COMPANY_____ **SUBSCRIBER NAME**_____ **DOB**____/____/_____

ID NUMBER_____**GROUP NUMBER**_____**EFFECTIVE DATE**____/_____/_____

SECONDARY HEALTH INSURANCE **Subscriber's SS# (if different than patient)** _____/_____/_____

INSURANCE COMPANY_____ **SUBSCRIBER NAME**_____ **DOB**____/____/_____

ID NUMBER_____**GROUP NUMBER**_____**EFFECTIVE DATE**____/_____/_____

IS THE PATIENT A MINOR? _____YES _____NO

PARENT'S NAME: _____

PARENT'S HOME ADDRESS:_____

HOME PHONE ( ) _____ **CELL PHONE ( )** _____ **WORK PHONE ( )** _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME _____ **RELATIONSHIP**_____

HOME PHONE ( ) _____ **CELL PHONE ( )** _____ **WORK PHONE ( )** _____

SECONDARY CONTACT_____ **RELATIONSHIP**_____

HOME PHONE ( ) _____ **CELL PHONE ( )** _____ **WORK PHONE ( )** _____

HAVE YOU COMPLETED ANY ADVANCED DIRECTIVES? _____YES _____NO

(If YES, check all that apply) _____ Living Will ____ DNR ____ Durable Power of Attorney

(If NO) Do you wish to learn more about Advance Directives? _____YES _____NO

South Georgia Center for Cancer Care Radiation Oncology
27 Coach Lee Hill Blvd, Statesboro, GA 30458 Phone: 912.764.3037 Fax 912.764.3829
www.sgcancer.com

SOUTH GEORGIA CENTER FOR CANCER CARE | RADIATION ONCOLOGY

PATIENT REGISTRATION

What Doctor referred you to our facility? _____
Who is you Primary Doctor? _____
Do you live in a Skilled Nursing Facility? No____ Yes____ Facility Name: _____
Do you have Hospice Care? No____ Yes____ Facility Name: _____

Why are you here to see us today? _____

Do you have or have had any of the following:

□ Heart Disease	□ Stomach Ulcer	□ Bipolar Disorder
□ Heart Murmur	□ Liver Disease	□ Anxiety
□ Heart Pacemaker/Defibrillator	□ Jaundice	□ Depression
□ Lung Disease	□ Anemia	□ Frequent Headaches
□ Heart Attack/Failure	□ Rheumatic Fever	□ Glaucoma
□ Stroke	□ Sickle Cell Disease	□ Bleeding Disorder
□ TIA	□ Thyroid/Parathyroid Disease	□ Shingles
□ Angina	□ Stomach/Intestinal Disease	□ Mitral Valve Prolapse
□ High Blood Pressure	□ Pneumonia (Recurring)	□ Osteoporosis
□ High Cholesterol	□ Kidney Disease	□ Gastroesophageal Reflux Disease (GERD)
□ Artificial Heart Valve	□ Renal Dialysis	□ Diabetes: Type_____
□ Congenital Heart Disorder	□ Bronchitis (Recurring)	□ Hypoglycemia (Low Blood Sugar)
□ Faint Spells/Dizziness	□ Sexually Transmitted Disease	□ Emphysema/COPD
□ Artificial Joint	□ AIDS/HIV Positive	□ Hives
□ Blood Disease/Leukemia	□ Hemophilia	□ Asthma
□ Blood Transfusion	□ Alzheimer's Disease	□ Tuberculosis
□ Bruise Easily	□ Parkinson's Disease	□ Valley Fever
□ Cancer: Type_____	□ Feeding Tube	□ Chronic Urinary Tract Infections
□ Chemotherapy/Immunotherapy	□ Diverticulosis	□ Scarlet Fever
□ Radiation Therapy	□ Peripheral Neuropathy	□ Hepatitis: A/B/C
□ Epilepsy or Seizures		□ Blood Clots
□ Atrial Fibrillation		

SOUTH GEORGIA CENTER FOR CANCER CARE | RADIATION ONCOLOGY

PATIENT REGISTRATION

Have you ever had any serious illness not listed above?

_____

_____

_____

PREVIOUS SURGERIES/HOSPITALIZATIONS **DATE**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MALE SCREENINGS **DATE**

Last PSA blood test _____
Last prostate digital rectal exam _____
Last colonoscopy _____

FEMALE HISTORY/SCREENINGS

Have you ever been pregnant _____YES _____NO
Number of Pregnancies _____
Number of Births _____
Age at First Birth _____
Age of Last Birth _____
First day of last menses _____
Age of Menopause _____ Reason for Menopause: ____ natural
Last colonoscopy _____ ____ hysterectomy
Last PAP smear _____ ____ ovary removal
Last mammogram _____ ____ chemotherapy

Have you ever taken birth control hormone? YES NO If YES, number of years taken_____
Have you ever taken fertility medication? YES NO If YES, number of years taken_____
Have you ever had anti-hormonal therapy? YES NO

SOCIAL HISTORY **TYPE** **FREQUENCY**

Do you drink alcoholic beverages? YES NO _____ _____
Do you use recreational drugs? YES NO _____ _____
Do you drink caffeinated beverages? YES NO _____ _____
Do you currently use tobacco products? YES NO _____ _____
Have you ever used tobacco products? YES NO _____ _____

(If yes) What age did you start? _____ What age did you stop? _____

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PATIENT REGISTRATION

SOCIAL HISTORY CONTINUED

Current/Former occupation: _____ Are you retired? _____

Marital Status: ____Single ____Married ____Divorced ____Widowed

Do you live alone? Yes_____ No_____

How many people live in your home? ____ What is their relation to you? _____

Are you homeless? Yes_____ No_____

Are you incarcerated? Yes_____ No_____

Do you need transportation? Yes_____ No_____ Do you have friends/family willing to help out? Yes_____ No_____

What is your level of activity? Please check one

____ Sedentary (don't move around much)
____ Daily activities
____ Occasional Exercise
____ Light Exercise
____ Regular Exercise
____ Extensive Exercise

Nutrition – please check one

____ Regular meals
____ Liquid diet
____ Vegetarian/Vegan
____ Low salt diet
____ Nutritional supplements
____ Diabetic diet
____ Kosher diet
____ Low protein diet

PLEASE LIST ALL ALLERGIES:

NAME	REACTION

SOUTH GEORGIA CENTER FOR CANCER CARE | RADIATION ONCOLOGY

PATIENT REGISTRATION

MEDICATIONS_INCLUDING VITAMINS, SUPPLEMENTS AND HERBALS

DRUG	DOSE	FREQUENCY	START DATE	COMMENTS

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY HAD HEREDITARY CANCER GENETIC TESTING?

_____YES _____NO _____DON'T KNOW

IF YES, DO YOU HAVE ACCESS TO THE RESULTS? _____YES _____NO _____DON'T KNOW

TYPE OF GENETIC TESTING? _____

PLEASE LIST ANY BLOOD RELATIVES THAT HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES:

Relation	**Whose Side** Paternal/Maternal	**Status** Alive/Deceased	**Age at Diagnosis**	**Current Age**	**Cancer (List Type)**	**High Blood Pressure**	**Heart Attack**	**Stroke**	**Diabetes**

ANY ADDITIONAL BLOOD RELATIVES WITH DISEASES NOT LISTED?

_____

_____

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PATIENT REGISTRATION

REVIEW OF SYSTEMS – CHECK ALL THAT APPLY

GENERAL	GENITOURINARY	FEMALE BREAST/REPRODUCTIVE
☐ Fatigue level (0 – 10) _____	☐ Pain and/or burning with urination	☐ Do you perform self breast exams?
☐ Appetite _____ Good _____ Fair _____ Poor	☐ Blood in urine	☐ Breast masses/sores/lumps/nodules
☐ Total weight loss in last 6 months _____ pounds	☐ Problems starting, maintaining, completing urine flow	☐ Nipple discharge
☐ Fevers / chills / night sweats	☐ Urinary incontinence/leakage	☐ Nipple inversion
NEUROLOGICAL	☐ Urinary frequency and/or urgency	☐ Breast pain
☐ Headaches	☐ Frequent urination at night	☐ Vaginal sores/nodules/lumps
☐ Vertigo (dizziness)	**GASTROINTESTINAL**	☐ Irregular vaginal bleeding/discharge
☐ Syncope (fainting)	☐ Constipation	☐ Pain with intercourse
☐ Ataxia (lack of coordination)	☐ Diarrhea	☐ Heavy menstrual bleeding
☐ Changes in speech	☐ Nausea and/or vomiting	**MALE REPRODUCTIVE**
☐ Change in memory/concentration	☐ Acid reflux	☐ Erectile dysfunction
☐ Confusion	☐ Blood in vomit	☐ Mass, lump, or pain in testicles
CARDIOVASCULAR	☐ Blood in stool	☐ Curvature of the penis
☐ Irregular heartbeat	☐ Abdominal pain	☐ Pain with intercourse
☐ Chest pain / Palpitations	**EYES**	**MUSCULOSKELETAL**
☐ Swelling	☐ Blurred Vision	☐ Weakness
☐ Pacemaker/Defibrillator	☐ Excessive eye watering	☐ Numbness
RESPIRATORY	☐ Visual difficulties	☐ Bone pain
☐ Shortness of breath	**EARS NOSE THROAT**	☐ Recent falls
☐ Cough	☐ Hearing loss: (Circle) R L Both	☐ Use of assistive device Type:
☐ Hemoptysis (Coughing up blood)	☐ Ear pain	**INTEGUMENTARY**
☐ Asthma	☐ Ringing in ears	☐ Jaundice
☐ Trouble breathing while lying flat	☐ Sinus drainage	☐ Edema/Swelling
☐ Do you use Oxygen?	☐ Nose bleeds	☐ Skin rashes/Itching
ENDOCRINE	☐ Sores on tongue or gums	☐ Wound/Sore
☐ Hot flashes	☐ Difficulty swallowing	☐ Nodules/Lumps
HEMATOLOGIC	☐ Altered taste	☐ Healing incision
☐ Anemia	☐ Hoarseness or change in voice	☐ Vascular Access Type: Location_____
☐ Blood clots	☐ Lumps in neck	**PSYCOLOGIC**
☐ Abnormal bruising	**IMMUNOLOGIC**	☐ Depression/Sadness
☐ Low blood counts	☐ Frequent colds	☐ Anxiety
☐ Blood transfusions	☐ Outdoor allergies	☐ Trouble sleeping
	☐ Cold sores	☐ Thoughts of suicide
	☐ Serious infections	☐ Frequent mood swings
	☐ Autoimmune disorder Type:	
	☐ Sepsis	

OTHER SYMPTOMS/CONCERNS:

_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be
dangerous to my (or patient's) health. It is my responsibility to inform the physician's office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

Medical Records Release

Patient Name: _____ Date of Birth: _____
Social Security No._____

I hereby authorize South Georgia Center for Cancer Care to release or obtain any medical information and records concerning my treatment to my physicians and medical providers and any third-party carrier (insurance company or government agency) when requested for its use in connection with making or determining claim for such treatment and/or diagnosis.

Please release requested records:

_____
_____
_____
_____

The undersigned authorizes the release of records pertaining to:

1. Testing and/or treatment of AIDS and AIDS related disease YES_____ NO_____
2. Treatment for psychiatric illness YES_____NO_____
3. Treatment for drug and/or alcohol abuse YES_____NO_____

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing.

Signature of patient / representative_____

Address: _____
City: _____
Phone: _____
Name and relationship if other than self: _____
Office use only: Date received: _____ Date sent: _____ By: _____

Authorization to Release Records to Family/Friends

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

YES NO

May we leave a detailed message on your answering machine at home or on your cell phone?

YES NO

May we discuss your medical condition with members of your family?

YES NO

If YES, please name all members ALLOWED to receive communication regarding your medical condition and billing information:

Name	Relationship

This consent was signed by (PRINT NAME): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

SOUTH GEORGIA CENTER FOR CANCER CARE
ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I agree to assign payment from my insurance companies for claims sent by **SOUTH GEORGIA CENTER FOR CANCER CARE, TAX IDENTIFICATION NUMBER 36-4866424** for any medical treatment rendered to me. If payment is mailed to me for claims submitted by South Georgia Center for Cancer Care, I will forward payment immediately. I also understand that if I have Medicare coverage, I will be responsible for payment of the portion not covered by Medicare if I do not have secondary coverage. I agree that should the amount of insurance benefits be insufficient to cover my expenses, I will be responsible for the difference. Statements are payable at time of receipt unless prior arrangements have been made.

_____

Please print your name here

_____

Signature

_____

Date

CONSENT FOR TREATMENT

The following information is to be completed by the patient or the patient's legally authorized representative:

By signing this form, I consent to medical treatment for myself for myself or for the patient for whom I am legally authorized representative.

_____

Signature of Patient

Date: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative: _____

Date: _____

SOUTH GEORGIA CENTER FOR CANCER CARE | RADIATION ONCOLOGY

PATIENT REGISTRATION

SOUTH GEORGIA CENTER FOR CANCER CARE
CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purpose of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

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SOUTH GEORGIA CENTER FOR CANCER CARE | RADIATION ONCOLOGY

PATIENT REGISTRATION

Electronic Mail User Authorization Form
Patient Portal

The patient Portal offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal records: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this Electronic Mail User Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

TERMS

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this Electronic Mail User Authorization Form. Please write legibly. I Do Not Wish to Participate in the Patient Portal

☐ I Do Not Wish to Participate in the Patient Portal

_____ Patient Name (First name, Middle Initial, Last Name)

_____ Email Address of Patient or Authorized

_____ Date of Birth of Patient

_____ Physician's Name

Authorized User is:

☐ Patient
☐ Patient's Designee

_____ Patient's Designee's Name (Printed)

_____ Patient's Designee's Signature

_____ Patient's Signature

_____ Date

_____ Signature of Practice Staff

_____ Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e, the Patient's Designated User) understands and agrees to use the listed email address for this phone.

PREFERRED PHARMACY, LABORATORY AND HOSPITAL INFORMATION SHEET

Patient's Name: _____

Patient's Date of Birth: _____

Preferred Pharmacy: _____ Phone#: _____

Preferred Laboratory: _____

Preferred Hospital: _____

**Please update this information as it may change during your care with South Georgia Center for Cancer Care

Patient's Signature or Signature of Patient's Representative Date

_____ _____

CONSENT TO BE PHOTOGRAPHED

This is to certify that I hereby give permission to the staff of South Georgia Center for Cancer Care to take such photographs of me as in their sole judgement may be valuable for confidential record and teaching purposes.

Patient's Signature or Signature of Patient's Representative Date

_____ _____