Los Angeles Cancer Network
A Partner of OneOncology

REGISTRATION PACKET

Welcome to Los Angeles Cancer Network. We want to thank you for entrusting us for your care. Our mission is to provide unparalleled care to each patient that comes through our doors. We offer individualized treatment using the most recent and relevant proven advances in cancer care, curated with deliberation and compassion. Rest assured, your doctor will do everything they can to help you through this process.

Attached please find a New Patient Registration Packet containing the following:

- Page 0: Explanation of Paperwork (This Page)
- Page 1: Patient Registration & Demographics
- Page 2-3: Review of Systems, OBGYN & Preventative Health History
- Page 4: Personal Medical History, Social History, Hospitalization History
- Page 5: Vaccination History, Advance Directives, & PHQ-2
- Page 6: Family Health History
- Page 7: Medication & Allergy List
- Page 8-9: Authorization for Release of Health Information
- Page 10-11: Notice of Privacy Practices

Please complete all forms and bring them with you to your first appointment, along with your current insurance cards and photo ID.

As a service to you, we provide registration and verification of insurance and assistance with payment arrangements, if needed. We work extensively with insurance companies to have claims paid at their maximum benefit to keep your financial burden to a minimum.

You will receive an automated reminder of your scheduled appointment via phone on the Sunday before your first visit. Please listen and respond to the options given to confirm your appointment.

A repeated pattern of no shows and/or canceled appointments may result in termination of the provider/patient relationship. Additionally, we may charge a fee for not showing up to a scheduled appointment. If you need to reschedule, please do so at least 24 hours in advance.

Please arrive at our office 30 minutes early for your first scheduled appointment to allow ample registration time. Please be advised that there could be additional forms that will need to be completed upon your arrival.

A surgical mask must be worn at all times during the duration of your visit (no cloth masks). We do allow for a maximum of one guest per patient, and this guest is required to adhere to our mask regulations as well.

If you have any questions concerning the above information, please do not hesitate to contact us.

Please indicate that you have read the above information.

Signature: _____ Today's Date: ____/_____/_____

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NEW PATIENT REGISTRATION

PATIENT ID

Patient Name (First, Middle, Last) : _____

Preferred Name: _____ Sex (Circle): M F Non-Binary Other: _____

ADDRESS Street: _____ City: _____ Zip: _____ State: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ okay to receive email updates? ☐ Yes ☐ No

Date of Birth: ____/____/_____ Age: ____ SSN: _____ Marital Status: _____

Primary Language: _____ Secondary Language: _____

Race: _____ Ethnicity: _____ **How did you hear about us? Circle One Below:**

Yelp, Google, Website, Social Media, Print Ad, Drive By, MD Referral, Friend/Family Referral, Other

MD Referral: _____ Patient Referral: _____ Other: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

PRIMARY CARE PHYSICIAN

MD Name: _____ Phone: _____ Fax: _____

Were you referred to us by a doctor other than your primary care physician? Circle Y / N If yes:

Referring MD Name: _____ Phone: _____ Fax: _____

INSURANCE INFORMATION

Primary Ins: _____ ID: _____ Group #: _____

Policy Holder: _____ D.O.B: ___/___/_____ Relationship: _____

Secondary Ins: _____ ID: _____ Group #: _____

Policy Holder: _____ D.O.B: ___/___/_____ Relationship: _____

I authorize payment of medical benefits to Los Angeles Hematology-Oncology Medical group with my current insurance carrier as reflected above.

Signature: _____ Date: _____ Employee Initials: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____ State: _____

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REVIEW OF SYSTEMS

NEW PATIENT QUESTIONNAIRE

Name: _____ D.O.B.___/___/_____ Date Completed: _____

Dear patient,

To ensure optimal care for you, we need to understand your complete health status and health history. With this goal in mind, we appreciate you spending 10-20 minutes completing this comprehensive health questionnaire as accurately as possible.

REVIEW OF SYSTEMS

For the Review of Systems, please indicate "Yes" if you are currently experiencing the symptom or if you have experienced the symptom within the past three months.

Please fill in the appropriate bubble completely. For example ■ Yes ☐ No

General/Constitutional

Anorexia ..... ☐ Yes ☐ No

Fatigue/Weakness ..... ☐ Yes ☐ No

Weight Loss ..... ☐ Yes ☐ No

Fever ..... ☐ Yes ☐ No

Sweats/Night Sweats ..... ☐ Yes ☐ No

Hot Flashes ..... ☐ Yes ☐ No

Neurological

Headache ..... ☐ Yes ☐ No

Neuropathy ..... ☐ Yes ☐ No

Dizziness ..... ☐ Yes ☐ No

Confusion ..... ☐ Yes ☐ No

Ears, Nose, Throat, Mouth

Hearing Loss ..... ☐ Yes ☐ No

Mouth Sores ..... ☐ Yes ☐ No

Dry Mouth ..... ☐ Yes ☐ No

Eyes

Blurred Vision ..... ☐ Yes ☐ No

Excessive Tearing ..... ☐ Yes ☐ No

Dry Eyes ..... ☐ Yes ☐ No

Cardiovascular

Chest Pain ..... ☐ Yes ☐ No

Palpitations ..... ☐ Yes ☐ No

Swelling of Legs ..... ☐ Yes ☐ No

Respiratory

Shortness of Breath ..... ☐ Yes ☐ No

Shortness of Breath at rest ..... ☐ Yes ☐ No

Shortness of Breath with exertion ..... ☐ Yes ☐ No

Cough ..... ☐ Yes ☐ No

Chest Pain ..... ☐ Yes ☐ No

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REVIEW OF SYSTEMS & OBGYN

Gastrointestinal

Abdominal Pain..... ☐ Yes ☐ No
Nausea..... ☐ Yes ☐ No
Vomiting..... ☐ Yes ☐ No
Diarrhea..... ☐ Yes ☐ No
Constipation..... ☐ Yes ☐ No
Blood in Stool..... ☐ Yes ☐ No
Heartburn..... ☐ Yes ☐ No

Musculoskeletal

Bone Pain..... ☐ Yes ☐ No
Joint Pain..... ☐ Yes ☐ No
Back Pain..... ☐ Yes ☐ No

Integumentary (Skin)

Rash..... ☐ Yes ☐ No
Itching..... ☐ Yes ☐ No

Endocrine

Cold Intolerance..... ☐ Yes ☐ No
Heat Intolerance..... ☐ Yes ☐ No

Hematologic/Lymphatics

Excessive or Spontaneous Bruising..... ☐ Yes ☐ No
Excessive or Spontaneous Bleeding... ☐ Yes ☐ No
Enlarged Lymph Nodes..... ☐ Yes ☐ No

Fatigue Rating **0 1 2 3 4 5 6 7 8 9 10**

Anxiety & Depression

Anxiety..... ☐ Yes ☐ No
Depression..... ☐ Yes ☐ No
Difficulty Sleeping..... ☐ Yes ☐ No

OBGYN HISTORY

Age of 1st Menstrual Period: _____ Date of Last Menstrual Period: _____

Birth Control Pills Used? Y N Other

Hormone Replacement Therapy Used? Y N If Yes, how many years? ____

Total Pregnancies: _____ Age when first child was born: _____ Number of Live Births: _____

Number of Miscarriages: _____ Number of Abortions _____ Number of C-Sections: _____

Number of Ectopic Pregnancies: _____

PREVENTATIVE HEALTH HISTORY – Indicate date of last screening: Month/Year

Pap Smear: _____ Mammogram: _____ Colonoscopy: _____

Bone Density: _____ Cholesterol: _____

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MEDICAL HISTORY

MEDICAL HISTORY – Please indicate if you have ever been diagnosed with or treated for any of the following conditions:

Asthma ☐ Yes
Bronchitis ☐ Yes
Hyperthyroidism ☐ Yes
Hypothyroidism ☐ Yes
Tuberculosis ☐ Yes
Thrombosis/Blood Clots ☐ Yes
Varicose Veins ☐ Yes
Diabetes, Type I (Insulin Dependent) ☐ Yes
Diabetes, Type II (Non-Insulin Dependent) ☐ Yes
Heart Murmur ☐ Yes
Hypercholesterolemia/High Cholesterol ☐ Yes
Hypertension/High Blood Pressure ☐ Yes
Coronary Artery Disease/Angina ☐ Yes
Abnormal Pap Smear ☐ Yes
Abnormal Uterine Bleeding ☐ Yes
Arthritis ☐ Yes
Rheumatoid Arthritis ☐ Yes
Schizophrenia ☐ Yes
Depression/Mania/Bipolar ☐ Yes

Neurologic Disorder ☐ Yes
Anxiety Disorder/Panic ☐ Yes
Carpal Tunnel ☐ Yes
Sleep Apnea ☐ Yes
Kidney Stones ☐ Yes
Kidney Disease ☐ Yes
Autoimmune Disorder ☐ Yes
HIV/AIDS ☐ Yes
Lupus ☐ Yes
Hepatitis B ☐ Yes
Hepatitis C ☐ Yes
Mitral Valve Prolapse ☐ Yes
Osteoporosis ☐ Yes
Gout ☐ Yes
Multiple Sclerosis ☐ Yes
Alcohol Abuse ☐ Yes
Drug Abuse ☐ Yes
Other Diagnosed ☐ Yes
List here: _____

SOCIAL HISTORY

Alcohol Consumption

Frequency:
☐ Less than 1 drink per week, ☐ 2-3 drinks per week, ☐ 1 drink per day, ☐ 2-3 per day, ☐ 3+ per day

Tobacco Use

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? _____

HOSPITALIZATIONS & SURGERIES

Month & Year	Reason for Surgery

VACCINATION HISTORY

Vaccination	Date last received
Covid-19 Vaccine– please indicate which vaccine (J&J, Pfizer, or Moderna)	
Influenza (Flu) Vaccine	
Pneumococcal Vaccine (for pneumonia)	
Hepatitis Vaccine	
HIV Vaccine	
Any other vaccination notes	

ADVANCE DIRECTIVES – legal documents regarding your wishes about medical care if you are no longer able to make them yourself.

Do you have a **living will**? If yes, please provide a copy. ☐ Yes ☐ No ☐ Unknown ☐ Would like to learn more

Do you have **durable power of attorney**? (a document that authorizes a person of your choice to manage your financial affairs if you become unable or unwilling to manage yourself) If yes, please provide a copy.

☐ Yes ☐ No ☐ Unknown ☐ Would like to learn more

Do you have a next of kin or **person who will make decisions for you** if needed? ☐ Yes ☐ No ☐ Unknown

If yes, please provide name, phone number, & relationship to you:

_____

Do you wish to receive CPR should your heart stop beating, or you stop breathing? ☐ Yes ☐ No, DNR (Do not resuscitate) ☐ Unknown

PATIENT HEALTH QUETIONNAIRE-2 (PHQ-2)

Over the **last two weeks**, how often have you been bothered by the following problems? Circle your answer.

Little interest or pleasure in doing things

Not at all Several Days More than half the days Nearly every day

Feeling down, depressed, or hopeless

Not at all Several Days More than half the days Nearly every day

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FAMILY HEALTH HISTORY

FAMILY HISTORY - Age at which family member was diagnosed

	Family Members	Status (A/D/U) Alive, Deceased, Unknown	Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Prostate Cancer	Stomach Cancer	Pancreatic Cancer	Melanoma	Heart Disease	High Blood Pressure	Diabetes	Other
	Example	*A*	*62*										*51*	*Lymphoma (68)*
Paternal Family	Father			N/A	N/A									
	Grandfather			N/A	N/A									
	Grandmother						N/A							
	Aunt						N/A							
	Uncle			N/A	N/A									
Maternal Family	Mother						N/A							
	Grandfather			N/A	N/A									
	Grandmother						N/A							
	Aunt						N/A							
	Uncle			N/A	N/A									
Personal	Self													
	Sister						N/A							
	Brother			N/A	N/A									

Other family health history notes:

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MEDICATION & ALLERGY LIST

CURRENT MEDICATIONS (including over-the-counter meds, vitamins, nutritional supplements, etc)

Name	Strength	Qty	Frequency	Start date	Stop Date

ALLERGIES

Substance	Reaction

Any additional notes you would like to share with your doctor:

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of your protected health information. Failure to provide all information requested may invalidate this authorization. By signing this document, it allows our office to communicate with and request records from your other doctors regarding your care and diagnosis. We will not share or request any information that does not specifically pertain to your treatment and care here with us at Los Angeles Cancer Network.

Patient Name: _____ Patient D.O.B: _____

USE & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____ to release to:

Persons/Organizations: **Los Angeles Cancer Network**

Address: _____

The following information:

a. ☐ All health information pertaining to my medical history, mental, or physical condition and treatment received OR
☐ Only the following records or types of health information (include a date range):

_____

_____

b. I specifically authorize release of the following information (check as appropriate):
☐ Mental Health Treatment Info _____ (Initial Here)
☐ HIV Test Results _____ (Initial Here)
☐ Alcohol/drug treatment information _____ (Initial Here)

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may obtain a copy of this authorization.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
  - 541 W Colorado St., Suite 205
    Glendale, CA 91204
- I may put an expiration on the authorization right now: _____

SIGNATURE

By signing this document, you are agreeing that you have read, received, and understood all parts of this document and are consenting to the use and disclosure of your medical records to our physicians so they can better serve you as a patient.

Today's Date: _____ Time: _____ ☐ AM ☐ PM

Print Name: _____ ☐ Patient ☐ Patient Representative

Signature: _____ ☐ Patient ☐ Patient Representative

If signed by a person other than patient, indicate relationship here: _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO FAMILY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

Completion of this document authorizes the disclosure of your protected health information. Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the result of tests, procedure, and financial information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members, you must sign this form.

Patient Name: _____Patient D.O.B:_____

USE & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **Los Angeles Cancer Network** to release my records and any information requested to the following individuals:

a. ☐ _____ Relationship: _____
☐ _____ Relationship: _____
☐ _____ Relationship: _____
☐ _____ Relationship: _____
☐ _____ Relationship: _____

b. Authorization Regarding Messages (please check all that apply)
- ☐ I authorize you to leave a detailed message on my home or cell number regarding my appointment dates & times.
- ☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results, or financial information.
- ☐ I authorize you to leave a message with anyone who answers my home or cell number regarding appointment date and times.
- ☐ I authorize you to leave a message with anyone who answers my home or cell number regarding medical treatment, care, test results, or financial information.
- ☐ Messages may only be left with _____

MY RIGHTS

- Filling out and signing this document is completely optional.
- I may obtain a copy of this authorization.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time (except where we have already made disclosures in reliance on your prior consent), but I must do so in writing and submit it to the following address:
  - **541 W Colorado St., Suite 205**
    Glendale, CA 91204
- I may put an expiration on the authorization right now: _____

SIGNATURE

By signing this document, you are agreeing that you have read, received, and understood all parts of this document and are consenting to the disclosure of your medical information to the persons listed above.

Print Name: _____ ☐ Patient ☐ Patient Representative **Date**: _____

Signature: _____ ☐ Patient ☐ Patient Representative **Date**: _____

If signed by a person other than patient, indicate relationship here: _____

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NOTICE OF PRIVACY PRACTICES

This **condensed** notice describes how medical information about you may be used, disclosed and how you can access this information. This notice applies to all the records of your care generated by the practice, whether made by the practice or an associated facility. Our practice provides the Notice to Comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA along with the Health Information Technology for Economic & Clinical Health (HITECH).

Law requires us to:

1) Make sure that the protected health information about you is kept private.
2) Provide you with a notice of our privacy practices and your legal rights with respect to protected health information about you.
3) Follow the conditions of the Notice that is currently in effect.
4) Keep all storage

We may use and disclose medical information about you for:

- **Treatment**- We may use protected health information about you to treat you with health care services. This will include doctors, nurses, laboratories, and any other personnel who is involved in your care.
- **Payment**- We may use and disclose protected health information about you with your insurance carrier so that services you receive may be billed, approved, and paid by your insurance company and/or third party.
- **Health care operations**- We may use and disclose protected health information about you for our practice operations.
- **Appointment and patient recall reminders**- We may use and disclose protected health information with our admin staff to contact you as a reminder that you have an appointment with our office.
- **Emergency situations**- We may use and disclose protected health information about you to an organization assisting in disaster relief effort or in an emergency, so that family can be notified about your condition, status, and location.
- **Required by law**- We may use and disclose protected health information about you in a situation when required to do so by federal, state, and local law.
- **Avert a serious threat to health safety**- We may use and disclose protected health information about you in a situation to help prevent the threat to your health and safety.
- **Organ or tissue donation**- We may use and disclose protected health information about you to facilitate organ or tissue donation and transplantation.
- **Workers' compensation**- We may use and disclose protected health information about you for workers' comp or similar programs.
- **Public health risk**- We may use and disclose protected health information about you in a situation when law or public policy may require us to disclose medical information for public health activities.
- **Investigation and government activities**- We may use and disclose protected health information about you to a local, state, or federal agency for activities authorized by law.

- **Lawsuits and disputes**- If you are involved in a lawsuit or a dispute, we may use and disclose protected health information about you in response to a court or administrative order.
- **Coroners**- We may use and disclose protected health information about you, if necessary, to identify a deceased person or determine the cause of death.
- **Inmates**- We may use and disclose protected health information about you to a correctional institution or law enforcement official if required by law.

Changes to this notice- We reserve the right to change this notice at any time, but you will be notified through the email you have provided on this form.

Complaints- If you believe your rights have been violated you can file a complaint with our privacy officer at Los Angeles Cancer Network or with the Secretary of the Department of Health and Human Services. To file a complaint, contact the manager in writing. All complaints will be investigated with our compliance officer without repercussion to you.

Compliance Officer for Los Angeles Cancer Network: Agatha Asemota agatha.asemota@oneoncology.com

Patient Rights: You have the following rights regarding your medical records.

*The right to inspect and have a copy of your chart.
*The right to amend your medical information in your chart.
*The right to an accounting disclosure.
*The right to a paper copy of this notice.
*The right to request restrictions or limitations of the medical information that we use.

By signing this form, you acknowledge that you have received, read, understand, and consent to the terms of our use and disclosure of health information about you as set forth in this notice.

Print Name:_____

Patient Signature:_____ **Date:** _____