CANCER CLINIC

New Patient Registration Form

Name: _____ **Date of birth:** _____ **Gender:** □M □F **Age:** _____
SSN: _____-_____-_____ **Ethnicity:** _____ **Preferred Language:** _____
Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Home Phone: (____) ____-_____ **Cell Phone:** (____) _____-_____ **Work Phone:** (____) _____-_____
Call Preference: □Home □Cell □Work **Email:** _____
Spouse Name: _____ **Spouse Phone:** _____
Emergency Contact Name: _____ **Emergency Contact Phone:** (____) ____-_____
Referring Doctor: _____
All doctors seen in past 2 years: _____
_____
Pharmacy Name: _____ **Phone:** (____) ____-_____ **Address:** _____
Reason for visit (describe): _____

PAST MEDICAL HISTORY: Please check any of YOUR previous conditions and provide year of diagnosis.

□ ____ Diabetes Type I
□ ____ Diabetes Type II
□ ____ Rheumatoid Arthritis
□ ____ Lupus/Autoimmune
□ ____ Anemia
□ ____ High Blood Pressure
□ ____ Coronary Artery Dis.
□ ____ High Cholesterol
□ ____ Blood Clots
□ ____ Heart Attack
□ ____ Atrial Fibrillation
□ ____ Blood Transfusion
□ ____ Stroke
□ ____ Epilepsy/Seizures
□ ____ Anxiety
□ ____ Depression
□ ____ Hepatitis A,B,C (CIRCLE)
□ ____ Liver Disease
□ ____ Kidney Disease
□ ____ Thyroid Disease
□ ____ HIV/AIDS
□ ____ HPV
□ ____ Hemorrhoids
□ ____ Asthma
□ ____ COPD
□ ____ Acid Reflux
□ ____ Peptic Ulcer
□ ____ Cancer (_____)
□ ____ Pacemaker
□ ____ Artificial Joints
□ ____ Metals in body
□ ____ Defibrillator
□ ____ Other (_____)

PAST SURGICAL HISTORY:

YEAR	TYPE	YEAR	TYPE

SOCIAL HISTORY:
Marital Status: □Married □Single □Divorce □Widowed
Number of children: _____ **Who you live with:** _____
Tobacco use: □Current □Former □Never **Type:** _____
Duration of use: _____ **Packs per day:** _____
If you quit, how long ago? _____ **Cessation Method:** _____
Alcohol use: □Does not drink □Former use □Drinks rarely □Drinks socially □Heavy drinker □Never
Duration of use: _____ **Drinking Frequency:** _____
Recreational Drugs: □Current □Former □Never **Type:** _____
Occupation (past or present): _____ **Presently working:** □Yes □ No
Advanced Directive: □Yes □ No **Living Will:** □Yes □ No **POA:** □Yes _____ □ No

IMMUNIZATIONS:
Last flu shot: _____ **Last pneumonia shot:** _____
Have you ever been vaccinated for shingles? □Yes □No **Date:** _____

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HEALTH MAINTENANCE:

Last Mammogram: _____ Last Pap Smear: _____
Last Colonoscopy: _____ Last Bone Density: _____
Are you under treatment with another physician for osteoporosis? □Yes □ No
Are you currently on dialysis? □Yes □ No **Appointment Time/Day:** _____

GYNECOLOGY HISTORY:

□Abnormal pap smear □Breast lump □Hot flashes □Nipple discharge □Nipple inversion
Age of first menstrual cycle: _____ Date of last menstrual cycle: _____
Pregnant: □Yes □No **Age when first child was born: _____ Breastfed Children:** □Yes □No
Use of hormone replacement therapy: □Yes □No **Use of birth control pills:** □Yes □No

REVIEW OF SYSTEMS: Please check ANY symptoms you are experiencing.

Constitutional: □Fever □Fatigue □Loss of appetite □Night sweats □Weight loss past 6 months: _____
Eyes: □Blurred vision □Difficulty seeing □Double vision
Ear/Nose/Throat: □Sore throat □Difficulty swallowing □Hoarseness □Nose bleeds
□Ringing in ears □Loss of hearing □Sinus trouble
Cardiac: □Chest pain □Palpitations □Lightheadedness □Swelling in ankles
Respiratory: □Shortness of breath □Chronic cough □Blood in sputum
Gastrointestinal: □Nausea □Vomiting □Indigestion/Heartburn □Diarrhea □Abdominal pain □Bowel incontinence □Bloating □Blood in stool □Constipation
Urologic: □Frequent □Urgent □Blood in urine □Lack of bladder control □Pain or burning with urination
Musculoskeletal: □Joint pain □Back pain
Skin: □Chronic rashes □Itching □Other _____
Neurological: □Weakness in arms or legs □Headaches □Seizure □Fainting □Dizziness □Prior stroke
□Muscle weakness/tingling/numbness □Difficulty thinking clearly □Loss of balance
Hematologic/Lymphatic: □Bruising □Bleeding □Armpit lump □Neck lump □Groin lump

PAIN SCALE: Please rate your pain from 0 to 10. 0 = No pain 10 = Severe pain
Pain rating: _____ Pain Location: _____

ALLERGIES:

ALLERGY	TYPE OF REACTION	MEDICATION

***Do you have an IODINE allergy?** □Yes □No

CURRENT MEDICATIONS: Please list CURRENT prescription, over the counter, and herbal medicine.

NAME	MG	FREQUENCY	NAME	MG	FREQUENCY

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Your provider will use this information as a screening tool for cancers that run in families. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces, and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, **ovarian**, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of **other cancers**?	☐ Y ☐ N	**List them here:**		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	**Who?**	**What gene(s)?**	**What was the result?**

Your provider will use the following information to determine if you should consider carrier screening.

Do you plan to become pregnant in the next year?	☐ Y ☐ N	Do you have Ashkenazi Jewish ancestry?	☐ Y ☐ N

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk®
COLARIS®PLUS with Myriad myRisk® ☐ COLARIS *AP*®PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update
Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

Cancer Clinic
INSURANCE POLICYHOLDER INFORMATION

Patient Name: _____ DOB: _____

PRIMARY INSURANCE INFORMATION:

Insurance Name: _____ I.D. Number: _____
Insurance Address: _____ Group Number: _____
Policyholder Name: _____ Policyholder DOB: _____
Policyholder SSN: _____-____-_____ Policyholder Gender: □Male □Female

SECONDARY INSURANCE INFORMATION (if applicable):

Insurance Name: _____ I.D. Number: _____
Insurance Address: _____ Group Number: _____
Policyholder Name: _____ Policyholder DOB: _____
Policyholder SSN: _____-____-_____ Policyholder Gender: □Male □Female

INSURANCE ASSIGNMENT

I request that payment under my medical insurance program be made to Kumud S. Tripathy and Associates, PA or Cancer Clinic on any bills for services. I / We understand that I am responsible for out of pocket expenses as indicated by my insurance plan. I agree to pay the amount my insurance company designates as my responsibility.

_____ _____ _____
Patient/Legal Representative (*Print*) Patient/Legal Representative (*Signature*) Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I, _____ (print patient name), have received a copy of CANCER CLINIC'S Notice of Privacy Practices which explains how my medical information may be used and disclosed. I have reviewed said notice. I understand that Cancer Clinic has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

_____ _____ _____
Patient/Legal Representative (*Print*) Patient/Legal Representative (*Signature*) Date

Cancer Clinic

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **DOB: _____**
Address: _____ **Phone: (____)____-_____**

I hereby authorize:

_____ _____ (____)____-_____
Name of Provider/Hospital/Physician Provider/Hospital/Physician Address Phone Number

To release the following information from my health record covering the period from _____ to _____. If I do not specify a period, I am authorizing the release of records for the entire duration of care with the provider. *(Check all that apply below.)*

- ☐ Complete Medical Record (insurance, demographics, referral documents, and medical records). ***If this box is checked, do not check any additional boxes.***
- ☐ Progress/Office Visit Notes
- ☐ Chemotherapy/Radiation Records
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Billing/Payment Records
- ☐ Anatomy/Pathology

Information is to be released to:
The Cancer Clinic
2215 E. Villa Maria Suite 110
Bryan, TX 77802
Phone: (979) 776-2000
Fax: (979) 776-0427

The information is being released for the following purposes:

- ☐ Continued Care/Treatment
- ☐ Disability
- ☐ Attorney/Litigation
- ☐ Other: _____

I understand that the information to be released or disclosed may include information relating to, mental health, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Further, I understand the following:
a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. For example, if I revoke it after the requested records are sent, the releasing party will not retrieve those records.
b. The information released in response to this authorization may be redisclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

This authorization shall be in force and effect until _____ year(s) from date of execution, at which time this authorization expires.

_____ _____ _____
Patient/Legal Representative (*Print*) Patient/Legal Representative (*Signature*) Date

☐ **REVOKE / CANCEL THIS AUTHORIZATION**

_____ _____
Patient/Legal Representative (*Signature*) Date

Cancer Clinic

PATIENT AUTHORIZATION TO COMMUNICATE AND DISCLOSE PHI

Patient Name: _____ **DOB: _____**
Address: _____ **Phone: (____)____-_____**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). Individuals may also request confidential communication of their PHI or that a communication of PHI be made by alternative means or communicated to authorized designated parties, including family members.

I wish to be contacted in the following manner (check all that apply):

□ Home Phone
- ○ Leave message with detailed information
- ○ Leave message with only call back details

□ Cell Phone
- ○ Leave message with detailed information
- ○ Leave message with only call back details

I hereby authorize one or all of the designated parties identified below to request, discuss, and receive only the PHI specified below:

- □ Complete Medical Record (insurance, demographics, referral documents, and medical records). ***If this box is checked, do not check any additional boxes.***
- □ Progress/Office Visit Notes
- □ Chemotherapy/Radiation Records
- □ Lab Reports
- □ Radiology Reports
- □ Billing/Payment Records
- □ Anatomy/Pathology

I understand that the identity of designees must be verified before release of PHI.

Authorized Designees:

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Name: _____ Relationship: _____ Phone: (_____)_____-_____

Name: _____ Relationship: _____ Phone: (_____)_____-_____

The designees named above are authorized to obtain information in the following manner(s) (check all that apply):

- □ Verbally: for example, via phone, face-top-face
- □ Written or printed format: for example, by obtaining medical record copies

This authorization shall remain in effect from the date signed below until revoked. You have the right to revoke this authorization in writing.

- I understand that the information to be released or disclosed may include information relating to, mental health, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.
- I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. For example, if I revoke it after the requested records are sent, the releasing party will not retrieve those records.
- I understand that I have the right to inspect or copy the PHI to be disclosed.
- I understand that information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization

_____ _____ _____

Patient/Legal Representative (*Print*) Patient/Legal Representative (*Signature*) Date

Cancer Clinic

ADVANCE DIRECTIVES INFORMATION SHEET

An advance directive is a legal document that tells your family, friends and healthcare professionals the care you would like to have if you become unable to make medical decisions. Through advance directives, you can make legally valid decisions about your future medical treatment.

You do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

There are three advance directives recognized in Texas:

- The **Texas Medical Power of Attorney** appoints someone to speak on your behalf any time you are unable to make your own medical decisions, not only at the end of life. Your attending physician must certify in writing that you are unable to make health care decisions and file the certification in your medical record. If you would like more information and a copy of the Texas Medical Power of Attorney form please ask the front desk staff.

- A **living will**, officially known in Texas as the Directive to Physicians and Family or Surrogates, describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will should be signed, dated and witnessed by two people, preferably individuals who know you well but are not related to you and are not your potential heirs or your health care providers. If you would like more information and a copy of the Directive to Physicians and Family Members form please ask the front desk staff.

- The **Out-of-Hospital Do Not Resuscitate (DNR)** order provides you with the right to withhold or withdraw cardiopulmonary resuscitation (CPR) or other treatments such as defibrillation and artificial ventilation. If you would like more information and a copy of the Texas Department of Health Services Standard Out of Hospital Do Not Resuscitate form please ask the front desk staff.

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

In order to make your directive legally binding, you must sign it, or direct another person to sign it, in the presence of two witnesses who must also sign the document.

It is our responsibility to inform all competent adult patients about Advance Healthcare Directives and ask whether they have one in place. The staff is instructed to know the different types of advance directives. All staff members know where to direct patients who have questions or want more information about advance directives. If a patient provides an advance directive to the Cancer Clinic, the physicians and staff should know the patient's decisions related to treatment.

Cancer Clinic

ADVANCE DIRECTIVES CONFIRMATION FORM

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or older who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

YES, I have an Advance Healthcare Directive(s). **(Please indicate which advance directive(s) you have below.)**

- ❑ Living Will, officially known as the Directive to Physicians and Family or Surrogates
- ❑ Texas Durable Medical Power of Attorney
  Name of POA: _____
- ❑ Out of Hospital Do Not Resuscitate (DNR)

If you have selected YES, please provide a copy of your advance directive to the front office staff.*

- ❑ **NO,** I do not have Advance Healthcare Directives. I understand that I can request more information about advance directives.
  - ❑ I would like additional information about the three advance directives recognized in Texas.

I, _____ (PRINT PATIENT NAME) have received the information regarding advance healthcare directives.

_____	_____	_____
Patient Signature	**Patient Date of Birth**	**Today's Date**

Cancer Clinic

PATIENT PORTAL

Patient Name: _____ DOB: _____

The team at Cancer Clinic would like to invite you to register for CareSpace, our patient portal. CareSpace gives you secure online access to your health information and care team.

In order to provide you access to CareSpace, we must have a valid email address.

Please select an option below:

_____ I **would like** to receive an invitation to CareSpace.

Email address: _____

_____ I **would NOT like** to receive an invitation to CareSpace.

□ I do not have an email address.

_____ _____ _____

Patient/Legal Representative (*Print*) Patient/Legal Representative (*Signature*) Date

INSTRUCTIONS FOR CARESPACE PORTAL

WWW.CARESPACEPORTAL.COM

Check your inbox and spam folder.

- □ You will receive an email titled "Complete Registration for your Cancer Clinic, dba Kumud Tripathy & Associates CareSpace Account"
- □ Select "Complete Registration"
- □ Register for CARESPACE.
    - You must use a symbol in your password.
    - You must use Google as the browser for Carespace to work.
- □ Please register within 4 days of when the email was sent.