Cancer Clinic

# Patient Registration Form

**Name:** _____ **Date of Birth:** _____

**SS#:** _____ **Email Address:** _____ ❑ Male ❑ Female

**Race:** _____ **Latino** ❑ Yes ❑ No **Language Spoken:** _____

**Address:** _____ **City:** _____ **Zip Code:** _____

**Home Phone:** _____ **Work phone:** _____ **Cell Phone:** _____

**Spouse Name:** _____ **Spouse Date of Birth:** _____

**Emergency Contact Name:** _____ **Emergency Contact Number:** _____

**How would you like to be contacted by our office** ❑ Phone ❑ Email

**Referring Doctor:** _____

**All Doctors seen during last 2 years:** _____

_____

**Pharmacy Preference (include location):** _____

**Disease/symptoms for this visit (please describe):** _____

_____

_____

**PAST MEDICAL HISTORY: Check if YOU have ever been diagnosed with:**

| | | | |
|---|---|---|---|
| Diabetes | ❑ YR diagnosed _____ | Liver Disease | ❑ YR diagnosed _____ |
| High Blood Pressure | ❑ YR diagnosed _____ | Thyroid Disease | ❑ YR diagnosed _____ |
| Heart Attack | ❑ YR diagnosed _____ | Anemia | ❑ YR diagnosed _____ |
| Coronary Artery Disease | ❑ YR diagnosed _____ | Lupus/Autoimmune Disease | ❑ YR diagnosed _____ |
| High Cholesterol | ❑ YR diagnosed _____ | Acid Reflux | ❑ YR diagnosed _____ |
| Arthritis | ❑ YR diagnosed _____ | Peptic Ulcer | ❑ YR diagnosed _____ |
| Asthma | ❑ YR diagnosed _____ | Hepatitis Type A, B, C | ❑ YR diagnosed _____ |
| COPD | ❑ YR diagnosed _____ | Hemorrhoids | ❑ YR diagnosed _____ |
| Anxiety/Depression | ❑ YR diagnosed _____ | HIV Infection | ❑ YR diagnosed _____ |
| Cancer (type) | ❑ YR diagnosed _____ | Blood Transfusion | ❑ Last Transfusion _____ |
| Stroke | ❑ YR diagnosed _____ | Blood Clots | ❑ YR diagnosed _____ |
| Kidney Disease | ❑ YR diagnosed _____ | OTHER _____ | |

**SURGERIES:**

| YEAR | TYPE OF SURGERY | YEAR | TYPE OF SURGERY |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**FAMILY HISTORY OF CANCER:**

Mother _____ Father _____

Brothers _____ Sisters _____

Children _____

Other illness in family _____

**SOCIAL HISTORY:**

Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single Number of Children: _____

You live with: _____

Tobacco use: ❑ Current ❑ Former ❑ Never Duration of smoking: _____ years

How many packs per day _____ If you quit, how long ago _____

Alcohol use: ❑ Does not drink ❑ Former use ❑ Drinks rarely ❑ Drinks socially ❑ Heavy Drinker ❑ Never

Duration of use: _____ years

How much drinking when quit _____

Recreational Drugs: ❑ Current ❑ Former ❑ Never Type: _____

Occupation: *(past or present)* _____ Presently working: ❑ Yes ❑ No

**CONTINUED ON BACK**

Cancer Clinic

# Patient Registration Form (Continued)

**HEALTH MAINTENANCE:**

Last Mammogram: Month _____ YR _____ Last Pap Smear: Month _____ YR _____
Last Colonoscopy: YR _____ Bone density: Month _____ YR _____

**GYN HISTORY:**

Age of first menstrual cycle: _____ Year of last menstrual cycle: _____
How old were you when your first child was born: _____ Did you breast feed your children? ❑ Yes ❑ No
Did you use hormone replacement therapy: ❑ Yes ❑ No

**REVIEW OF SYSTEMS: Check ANY of the symptoms you are having:**

Constitutional: ❑ Fever ❑ Fatigue ❑ Loss of appetite ❑ Night sweats
❑ Weightloss over the past 6 months _____
Eyes: ❑ Blurred vision ❑ Difficulty seeing ❑ Double vision
Ear/Nose/Throat: ❑ Sore throat ❑ Hoarseness ❑ Pain ❑ Difficulty swallowing ❑ Nose bleeds
❑ Hearing loss ❑ Ringing in ears ❑ Sinus trouble
Cardiac: ❑ Chest pain ❑ Palpitations ❑ Lightheadedness ❑ Ankle swelling
Respiratory: ❑ Shortness of breath ❑ Cough ❑ Blood in sputum
Gastrointestinal: ❑ Nausea ❑ Vomiting ❑ Heartburn ❑ Diarrhea ❑ Abdominal pain
❑ Bowel incontinence ❑ Blood in stool ❑ Constipation
Urologic: ❑ Frequency ❑ Urgency ❑ Pain or burning with urination ❑ Blood in urine ❑ Urine incontinence
Musculoskeletal: ❑ Joint pain ❑ Back pain
Skin: ❑ Rashes ❑ Itching Other _____
Neurological: ❑ Weakness of arms or legs ❑ Headaches ❑ Seizure ❑ Fainting spells ❑ Dizziness
❑ Numbness / tingling ❑ Difficulty thinking clearly ❑ Loss of balance
Psychiatric: ❑ Nervousness ❑ Anxiety ❑ Depression ❑ Difficulty sleeping
Blood/Lymph System: ❑ Bruising ❑ Bleeding (anywhere) ❑ Lumps in armpits ❑ Lumps in neck ❑ Lumps in groin

**PAIN SCALE: please rate your pain from 0 to 10 0 = No pain 10 = Very severe**

"I rate my pain as number _____"
Location of pain: _____

**MEDICATION ALLERGIES:**

| ALLERGY | TYPE OF REACTION |
|---|---|
| | |
| | |
| | |

**CURRENT MEDICATIONS: Please list CURRENT prescription medicines, over-the-counter medicines, herbal medicines. Please include DOSE in milligrams (MG) and how often you are taking them.**

| NAME | MG | HOW OFTEN | NAME | MG | HOW OFTEN |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**IMMUNIZATIONS:**

Last Flu shot: YR _____ Last Pneumonia shot: YR _____
Have you ever been vaccinated for Shingles: ❑ No ❑ Yes When _____

Cancer Clinic

# MEDICARE PATIENT REGISTRATION

**IF YOU ARE A MEDICARE PATIENT IT IS REQUIRED THAT YOU ANSWER THE FOLLOWING QUESTIONS:**

**Name:**_____

**Date:**_____

**1. Have you had a flu shot this past fall/winter?** ❑ Yes ❑ No

If yes, what was the approximate date? _____

**2. When and where was your last colonoscopy?** _____

_____

**3. Have you ever had a pneumonia vaccine?** ❑ Yes ❑ No

If yes, what was the approximate date? _____

**4. Do you smoke?** ❑ Yes ❑ No

If you used to smoke, when did you quit? _____

**5. Do you have a family history of any disease?** ❑ Yes ❑ No

If yes, what disease(s)? _____

**6. Do you have an advance directive / living will?** ❑ Yes ❑ No

If not, would you like to discuss that with our staff? ❑ Yes ❑ No

**7. Who is your power of attorney?** _____

**FOR WOMEN:**

**1. When was your last mammogram?**_____

**2. When was your last bone density?**_____

**3. Are you under treatment with another physician for osteoporosis?** ❑ Yes ❑ No

Cancer Clinic

# RECORDS RELEASE

**CANCER CLINIC**

**2215 E. Villa Maria #110 • Bryan, TX 77802**

**Kumud Tripathy MD, Terry Jenkins MD, and Erin Fleener MD**

**979.776.2000 phone | 979.776.0427 fax**

**Date:**_____

**To:** _____

_____

**I hereby Authorize release to:**

_____

_____

**any protected health information including the diagnosis and record of any treatment**

**or examination rendered to me during the period**

**from** _____ **to** _____

**x** _____

**Signature**

**x** _____

**Witness**

Cancer Clinic

**CANCER CLINIC**
**2215 E. Villa Maria #110 • Bryan, TX 77802**
**Kumud Tripathy MD, Terry Jenkins MD, and Erin Fleener MD**
**979.776.2000 phone | 979.776.0427 fax**

# RECEIPT NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

**I, _____(patient name), have received a copy of CANCER CLINIC'S Notice of Privacy Practices.**

**x** _____ _____

**Signature** **Date**

# BLANK INSURANCE ASSIGNMENT

**I request that payment under my medical insurance program be made to Kumud S. Tripathy MD and Associates or Cancer Clinic on any bills for services.**

**x** _____ _____

**Signature** **Date**

_____

**Name of Patient (Please Print)**

***I / We understand that my / our insurance company may not cover some or all services. Should this happen, I agree to pay the amount not paid or covered by the insurance company.***

**x** _____ _____

**Patient/Guardian Signature** **Date**