



**Welcome to Medical Oncology Associates of San Diego.** We want to thank you for entrusting us with 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 and our staff will do everything we can to help you through this process.

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

- Explanation of Paperwork (This Page)
- Patient Registration and Demographics
- Authorization for Release of Health Information
- Medical History
- 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.

We recommend that you arrive at our office 30 minutes early for your first scheduled appointment to allow ample time for registration and completion of any additional forms. Your initial consultation with your doctor may be up to 1 hour long. Please plan accordingly.

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

If you need to cancel or reschedule, please do so at least 24 hours in advance as a courtesy to other patients awaiting appointments. If you miss your initial appointment or cancel less than 24 hours prior to the visit, you may be charged a fee of \$50.

Follow up visits are typically 15 minutes long. If you arrive more than 10 minutes late, we may not be able to accommodate you that day. A repeated pattern of no-shows and/or canceled appointments may result in termination of the provider-patient relationship.

Our practice has a patient portal, CareSpace, that provides you and your caregiver easy access to your health information. CareSpace allows you to manage your medical appointments as well as send messages to your provider. If you would like to get access to CareSpace, talk to our front desk receptionists and they will be happy to assist you.

If you have any questions concerning the above information, please do not hesitate to contact us at (858)637-7888.

3075 Health Center Dr. Suite 102 San Diego, CA 92103  
5555 Reservoir Drive # 306 San Diego, CA 92120  
4060 4Th Ave. # 508 San Diego, CA 92103  
230 Prospect Place # 210 Coronado, CA 92118

Phone: 858-637-7888 / 619-287-9910  
Fax: 858-637-7887 / 619-287-352  
Email: [faxes@oncologysandiego.com](mailto:faxes@oncologysandiego.com)  
website: [oncologysandiego.com](http://oncologysandiego.com)



### Patient Registration

Today's Date: \_\_\_\_\_

Patient Name (First, Last): \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_ 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

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

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

Yelp, Google, Website, Social Media, MD or Patient Referral, Insurance Referral

**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 Medical Oncology Associates of San Diego with my**

**current insurance carrier as reflected above.**

The Open Payment database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>

**Patient Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

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**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 Medical Oncology Associates of San Diego.

**Patient Name:** \_\_\_\_\_ **Patient D.O.B:** \_\_\_\_\_

**USE & DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize: \_\_\_\_\_ to release to:

Persons/Organizations: **Medical Oncology Associates of San Diego**

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:  
3075 Health Center Drive # 102 San Diego, CA 92123
- 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.

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

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**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS**

Completion of this document authorizes the disclosure of your protected health 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/friend, you must sign this form.

**Patient Name:** \_\_\_\_\_ **Patient D.O.B.:** \_\_\_\_\_

**USE & DISCLOSURE OF HEALTH INFORMATION**

I hereby authorize: **Medical Oncology Associates of San Diego** to release my records and any information requested to the following individuals:

- a.  \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_
- \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_
- \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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
- 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:

**3075 Health Center Drive #102 San Diego, CA 92123**

- 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:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

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**New Patient Questionnaire**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

MD Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**PHARMACY INFORMATION**

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ State: \_\_\_\_\_

<b><u>DRUG ALLERGIES/REACTIONS:</u></b>

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Live Alone  Yes  No Who lives with you? \_\_\_\_\_

**Smoke?**

\_\_\_\_\_ Never  
\_\_\_\_\_ In the Past  
\_\_\_\_\_ Present  
\_\_\_\_\_ How many packs/days?

**Alcohol?**

\_\_\_\_\_ Daily  
\_\_\_\_\_ Occasional  
\_\_\_\_\_ None

**Other Substance use?**

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

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

<b>Prescription Meds., Vitamins and OTC Meds</b>	<b>DOSE – How many times per day</b>



**New Patient Questionnaire**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_\_

**PAST MEDICAL PROBLEMS (such as Diabetes, hypertension, etc.)**


**PAST HOSPITALIZATIONS & SURGERIES:**

Hospitalization/ Surgery	Date

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

Pap-Smear: \_\_\_\_\_ Mammogram: \_\_\_\_\_  
Colonoscopy: \_\_\_\_\_ Bone Density: \_\_\_\_\_



## New Patient Questionnaire

Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_\_

**FAMILY HISTORY** - Please fill in the following history information with any **CANCER or BLOOD DISORDERS only**

<b>PATIENT</b>	<b>Family members</b>	<b>Type of Cancer or Blood Disorder</b>	<b>Alive</b>	<b>Deceased</b>
	<b>Mother</b>			
	<b>Father</b>			
	<b>Children</b>			
	<b>Brother(s)</b>			
	<b>Sister (s)</b>			
<b>MATERNAL SIDE OF FAMILY</b>	<b>Family members</b>	<b>Type of Cancer or Blood Disorder</b>	<b>Alive</b>	<b>Deceased</b>
	<b>Grandmother</b>			
	<b>Grandfather</b>			
	<b>Aunt(s)</b>			
	<b>Uncle (s)</b>			
	<b>Cousin (s)</b>			
<b>PATERNAL SIDE OF FAMILY</b>	<b>Family members</b>	<b>Type of Cancer or Blood Disorder</b>	<b>Alive</b>	<b>Deceased</b>
	<b>Grandmother</b>			
	<b>Grandfather</b>			
	<b>Aunt (s)</b>			
	<b>Uncle (s)</b>			
	<b>Cousin (s)</b>			

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### New Patient Questionnaire

Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_\_

#### **VACCINATION HISTORY**

VACCINATION	DATE LAST RECEIVED
Influenza (Flu) Vaccine	
Pneumococcal Vaccine (Pneumonia)	
COVID-19 Vaccine. Please indicate which Vaccine (J&J, Pfizer or Moderna)	
Other:	

#### **EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**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**?  
 Yes  No **If yes, please provide a copy.**
- Do you have a **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)  
 Yes  No **If yes, please provide a copy to the front desk or provider.**
- Do you have a next of kin or person who will make decisions for you if needed?  
 Yes  No **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)
  - Have you completed a POLST?  
 Yes  No





**INITIAL AUTHORIZATION FOR THIRD-PARTY MEDICATION PICK -UP**

**SECTION 1: PATIENT INFORMATION**

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**SECTION 2: AUTHORIZED 3<sup>RD</sup> PARTY INFORMATION**

**1<sup>ST</sup> Person**

**Print Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**2<sup>nd</sup> Person**

**Print Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**3<sup>rd</sup> Person**

**Print Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**SECTION 3: PATIENT SIGNATURE AUTHORIZATION**

My signature below authorizes the 3<sup>rd</sup> party listed in this form to pick up my medication from my Provider's clinic and deliver it to me. I further acknowledge that once my medication is in the possession of the authorized 3<sup>rd</sup> party, it 'is my full responsibility to ensure that such 3<sup>rd</sup> party delivers the medication to me.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SECTION 4: FOR OFFICIAL USE ONLY**

Employee Name	Signature	Date
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The employee is to confirm receipt of each of the following items.

- Complete Authorization Form
- Verified Patient Signature

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