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, Care Space, that provides you and your caregiver easy access to your health information. Care Space allows you to manage your medical appointments as well as send messages to your provider. If you would like to get access to Care Space, 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.

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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website: oncologysandiego.com

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: ____

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: _____

Please write all drug allergies & reactions or write NONE

____

____

____

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.)

Prescription Meds., Vitamins and OTC Meds	DOSE – How many times per day

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

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

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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

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INITIAL AUTHORIZATION FOR THIRD-PARTY MEDICATION PICK -UP

SECTION 1: PATIENT INFORMATION

Print Name: ____ **Date:** __________________________

Physical Address: ____

Telephone: ____

SECTION 2: AUTHORIZED 3RD PARTY INFORMATION

1ST Person

Print Name: ____ Phone Number: ______________________

2nd Person

Print Name: ____ Phone Number: ______________________

3rd Person

Print Name: ____ Phone Number: ______________________

SECTION 3: PATIENT SIGNATURE AUTHORIZATION

My signature below authorizes the 3rd 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 rd. party, it 'is my full responsibility to ensure that such 3rd. party delivers the medication to me.

Signature: ____ **Date:** _________________________

SECTION 4: FOR OFFICIAL USE ONLY

____

Employee Name **Signature** **Date**

The employee is to confirm receipt of each of the following items.

- ☐ Complete Authorization Form
- ☐ Verified Patient Signature

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