New Patient Registration Form

Name:_____ **Date of birth:**_____ **Gender:** □M □F **Age:** ____
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

FAMILY HISTORY OF CANCER: Please specify type of cancer.
Mother:_____ **Father:**_____
Brother(s):_____ **Sister(s):**_____
Child:_____ **Other family illness:** _____

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

New Patient Registration Form

HEALTH MAINTENANCE:
Last Mammogram:_____ **Last Pap Smear:** _____
Last Colonoscopy:_____ **Last Bone Density:** _____

GYNOCOLOGY 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

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

NAME	MG	FREQUENCY	NAME	MG	FREQUENCY

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

CANCER CLINIC
MEDICARE PATIENT REGISTRATION FORM

If you are a Medicare patient, it is REQUIRED that you answer the following questions:

Name: _____ **DOB:** _____ **Date:** _____

1. **Have you had the flu shot in the previous fall/winter?** □Yes □No
   If yes, what is the approximate date? _____
2. **When and where was your last colonoscopy?** _____
3. **Have you ever had a pneumonia vaccine?** □Yes □No
   If yes, what is 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
   a. **If not, would you like to discuss that with our staff?** □Yes □No
7. **Who is your power of attorney?** _____

FOR WOMEN ONLY:

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
INSURANCE POLICYHOLDER INFORMATION

Patient Name:_____ **DOB:** _____

PRIMARY INSURANCE INFORMATION:

Insurance Name: Insurance
Address: Policyholder Name:
Policyholder SSN ----------_____

I.D. Number: _____
Group Number: _____
Policyholder DOB: _____
Policyholder Gender: □Male □Female

SECONDARY INSURANCE INFORMATION (if applicable):

Insurance Name: Insurance
Address: Policyholder Name:
Policyholder SSN ----------_____

I.D. Number: _____
Group Number: _____
Policyholder DOB: _____
Policyholder Gender: □Male □Female

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. 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

RECEIPT NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

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

X_____ _____
Patient Signature Date

CANCER CLINIC

PATIENT AUTHORIZATION FOR RELEASE OF MEDICALINFORMATION

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 entire duration of carewith the provider. *(Check all that apply below.)*

- □ Complete Medical Record (insurance, demographics, referral documents, and medicalrecords). ***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:

Dr .Nischal N Cancer Care Clinic
Mob number – 9326480662
Email- drnischal89@gmail.com
Address- Nanjappa Hospitals, Hadadi road, Davangere

The information is being released for the following purposes:

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

I understand that this authorization will remain in effect until I revoke it in writing.

I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or HealthInsurance Portability and Accountability Act), a re−disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

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

□ **REVOKE / CANCEL THIS AUTHORIZATION**

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

CANCER CLINIC

CORONAVIRUS (COVID-19) SCREENING FORM

Patient Name: _____ **Date of Birth:** _____
Today's Date: _____

Please note that we are taking precautionary steps and screening all of our patients to ensure that they are not infected with the coronavirus. During this time, we ask that NO VISITORS accompany you to your appointment. Please call us at (979) 776 – 2000 if you haveany concerns or feel that you need a guest to accompany you at your appointment.

Please answer the following questions by circling YES or NO:

- **Within the last 14 days, have you or your accompanying guest/family members travelled outside of the Brazos Valley area?** **YES NO**
  - **If so, to where?** _____
- **Within the last 14 days, have you or your accompanying guest/family members come in close contact with any person known to be positive for COVID-19?** **YES NO**
- **Within the last 14 days, have you or your accompanying guest/family members experienced any of the following symptoms?**
  - **Fever** **YES NO**
  - **Cough** **YES NO**
  - **Shortness of breath** **YES NO**

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.
□ I do not wish to provide my email address.

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

Contact-Us
Dr.Nischal N
Consultant and Oncosurgeon
MS , M.Ch Surgical oncology
(Tata Memorial Hospital, Mumbai)
Mob number – 9326480662
Email- drnischal89@gmail.com
Address- Nanjappa Hospitals, Hadadi road Davangere