Nancy N. and J.C. Lewis Cancer & Research Pavilion at St. Joseph's/Candler

PATIENT REGISTRATION

Clear Form | Print Form

Comprehensive Oncology Services

PATIENT DEMOGRAPHIC INFORMATION

Last Name _____ **First Name** _____ **Middle Name** _____

Primary Address _____

City _____ **State** _____ **Zipcode** _____

Secondary Address _____

City _____ **State** _____ **Zipcode** _____

Primary Phone _____ ☐ Home ☐ CELL **Second Phone** _____ ☐ CELL

Email Address _____

Would you like to receive electronic reminders ☐ Yes, via Email ☐ Yes, via SMS ☐ No, I decline

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil Union Spouse/ Partner Name _____

Your Birthdate _____ **Your Gender** ☐ Female ☐ Male **Your SSN** _____

Government Required Data

Race ☐ Asian / Asian Decent ☐ Black / African Decent ☐ Other ☐ Native American/Alaskan ☐ White / European Decent ☐ Native Hawaiian / Pacific Islander ☐ More than one race Please list: _____

Ethnicity ☐ Hispanic ☐ Non-Hispanic **Language** ☐ English ☐ Spanish ☐ Other _____

Education Lvl ☐ High School Diploma/GED ☐ Some College ☐ College Degree ☐ Post Graduate Degree

Occupation _____ Current or previous ☐ Retired **Employment** _____

Insurance information

Insurance Coverage ☐ YES ☐ NO If yes, please present your original cards

Primary Insurance Company _____ Effective Date _____

Secondary Insurance Company _____ ☐ Not Applicable

Insured DOB _____ Insured Name/SSN _____

Contact Information

Referring Provider _____ **Primary Care Provider** _____

Emergency Contact _____ **Relationship** _____

Contact Phone # _____ **Email Address** _____

Please list up to three(3) people that are authorized to access your medical records

1 _____ 2 _____ 3 _____

1

Office use : Patient ID _____ ○MedOnc ○RadOnc ○GynOnc ○MultiD ○PalMed ○CMOP ○Telfair ○SAV ○HHI ○BLF

Preferred ancillary services provider:

Retail Pharmacy: _____ Mail Order: _____

Laboratory Services: _____

_____ Initial

I understand that it is my responsibility to complete and update the ancillary services provider preferences as needed. Any charges that may be incurred due to incomplete, incorrect information will be my responsibility.

HIPAA NOTICE OF PRIVACY RIGHTS ACKNOWLEDGEMENT

_____ Initial

I hereby acknowledge that I have received a copy of the St. Joseph's | Candler Comprehensive Oncology Services Joint Notice of Privacy Rights.

BILLING ACKNOWLEDGEMENT

_____ Initial

I have been informed that I may receive more than one bill for my visits. You will receive a bill from your physician either Candler Oncology, SJC - SC Cancer Specialists or Candler Medical Oncology Practice and you may receive an additional bill from Candler Hospital for the facility, supplies, medication, nursing care, radiology, laboratory and therapies.

CONSENT FOR MEDICAL TREATMENT / MEDICAL RECORDS RELEASE

_____ Initial

I voluntarily consent to such health care services at St. Joseph's | Candler Health System and it's affiliated facilities and practices encompassing routine diagnostic procedures and medical treatments as may be ordered by healthcare providers responsible for such medical care. I further consent to treatment by authorized employees, agents or independent contractors of St. Joseph's | Candler who are assigned to my care. In addition, I am hereby consenting to the employees, agents or independent contractors of St. Joseph's | Candler to use and disclose my information to obtain payment of charges and for healthcare operations. I hereby consent and grant authorization to release any or all part of my patient record and the other information to my insurance company or other party including but not limited to pharmaceutical patient assistance programs on behalf of St. Joseph's | Candler responsible for payment of charges relating to the services I received. St. Joseph's | Candler may use and disclose the information to any agency or independent contractor review records for certification, utilization management and/or for quality assurance; on behalf of St. Joseph's | Candler and all affiliates or subsidiaries of St. Joseph's | Candler. Likewise, physicians and/or healthcare providers may release and/or obtain the same information for the continuation of care.

I certify that all above information is correct and it reflects the most accurate information to date. By signing below, I am requesting to be a patient of St. Joseph's | Candler Lewis Cancer & Research Pavilion and other St. Joseph's | Candler Oncology affiliated companies. I authorize the release of my medical records to my insurance company(s) as necessary to process my insurance claim(s) upon request. I authorize CMS, Medicare and/or my insurance company to release my benefit payments directly to St. Joseph's | Candler Hospital, Candler Oncology Services, Candler Medical Oncology Practice and SJC - SC Cancer Specialists for services rendered.

I understand and accept the financial policy of St. Joseph's | Candler Health System and of Candler Oncology Services, Candler Medical Oncology Practice and SJC - SC Cancer Specialists. I acknowledge that payment is expected when the services are rendered. I also further certify that the documents I have produced are in their original and unaltered state. I further certify that I am the legally authorized user of the identification I have produced, including but not limited to federal, state issued ID and insurance card(s).

I understand and accept the the contract that I have with my insurance company is mine. I further understand and accept that I am responsible for any services and balances that are not covered by that contract.

I understand that if my insurance requires a referral to see a specialist, then it is my responsibility to obtain that referral prior to being seen by that physician.

Patient, Parent or Guardian signature

Patient, Parent or Guardian printed name

Relationship to patient if not self

06/14/2018

Today's Date

Office use : Patient ID

YOUR MEDICAL HISTORY

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Name:_____ **Date Form Completed:** _____

Date of Birth:_____ **By Whom:** _____

Please check only information that applies.
When possible, if a date is required please enter the date. If date is not known, please enter a year.

Your Medical Problems

Have you had the following:	Yes	Month/Day/Year
Alzheimer's / Dementia	☐	
Anemia	☐	
Anxiety	☐	
Asthma	☐	
Atrial Fibrillation	☐	
Benign Enlargement of Prostate	☐	
Cancer (any type) Please list type:	☐	
Celiac Disease	☐	
Cirrhosis	☐	
COPD (Chronic Obstructive Pulmonary Disease)	☐	
Congestive Heart Failure	☐	
Coronary Artery Disease	☐	
Depression	☐	
Diabetes-Non Insulin Dependent (Type II)	☐	
Diabetes-Insulin Dependent (Type I)	☐	
Diverticulitis/Diverticulosis	☐	
DVT/Deep Vein Thrombosis	☐	
Gallstones	☐	
Gastro Esophageal Reflux Disease	☐	
Heart Attack	☐	
Hepatitis A	☐	
Hepatitis B	☐	
Hepatitis C	☐	
Hiatal Hernia	☐	
HIV/AIDS	☐	
Hyperlipidemia (High Cholesterol)	☐	

Have you had the following:	Yes	Month/Day/Year
Hypertension (High Blood Pressure)	☐	
Hyperthyroidism (high)	☐	
Hypothyroidism (low)	☐	
ITP (Idiopathic Thrombocytopenic Purpura)	☐	
Kidney Stones	☐	
Lupus	☐	
Melanoma	☐	
Osteoarthritis (Site:)	☐	
Osteopenia	☐	
Osteoporosis	☐	
Parkinson's Disease	☐	
Peripheral Neuropathy	☐	
Polycythemia Vera	☐	
Seizures	☐	
Sickle Cell Anemia	☐	
Stroke	☐	
Thalassemia	☐	
Thrombocytosis	☐	
Usual Childhood Illness (Measles, Mumps, Chicken Pox, etc.)	☐	
Other Conditions (Please List)		
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	

Your Surgical/Procedure History

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Procedures	Yes	Month/Day/Year
Ablation	☐	
AICD Placement	☐	
Appendectomy	☐	
Bone Marrow Aspiration	☐	
Bone Marrow Biopsy	☐	
Brain Surgery	☐	
Biopsy: type_____	☐	
Breast Implant	☐	
Bronchoscopy	☐	
Caesarean Section	☐	
Cataract Removal	☐	
Central Line Placement	☐	
Cholecystectomy	☐	
Colonoscopy	☐	
Colostomy	☐	
Colectomy	☐	
Colposcopy	☐	
Coronary Artery Bypass	☐	
Endoscopy, Upper	☐	
Gamma Knife	☐	
Hernia Repair	☐	
Other	☐	

Procedures	Yes	Month/Day/Year
Hysterectomy	☐	
Laminectomy	☐	
Lobectomy	☐	
Lumbar Puncture (Diagnostic)	☐	
Lumbar Puncture (Therapeutic)	☐	
Lumpectomy	☐	
Mammoplasty	☐	
Mastectomy	☐	
Pacemaker Placement	☐	
Paracentesis	☐	
PEG Tube	☐	
PET or PET/CT Scan	☐	
Radiation	☐	
Radiation Seeds	☐	
Thoracentesis	☐	
Tonsillectomy	☐	
Tubal Ligation	☐	
TURP	☐	
Vasectomy	☐	
Whipple	☐	
Transplant (specify type)	☐	
Other:	☐	

Gynecologic- Women Only

Pregnancies	
Number of Pregnancies:	
Live Births:	
Age at First Birth:	
Interrupted Pregnancies	
Menses	
Age at first Menstrual Cycle	
Last Menstrual Cycle (Date)	
Menstrual Cycle Length	
Current Gyn Physician	
Removal of Ovaries (date)	
Most recent Physician breast exam?	

Menopause: (check one) ☐Pre ☐Peri ☐Post ☐Unknown	
Age at Menopause:	
Reason: (check one)	☐Chemo ☐Other ☐Surgical ☐Natural
Last PAP (date)	
History of Abnormal Pap	Y / N #Years
Last Mammogram (date)	
Contraceptive Hormone Use	Y / N # Years:
Post Menopause Use	Y / N # Years:
Other Hormone Use	Y / N # Years:
When did you stop?	
Do you do self-breast exams?	Y / N
If yes, how frequent?	

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Your Family History

	Alive? YES	Alive? NO	Age at death	Please list any medical issues/history
Father	☐	☐		
Mother	☐	☐		
Maternal Grandfather	☐	☐		
Paternal Grandfather	☐	☐		
Maternal Grandmother	☐	☐		
Paternal Grandmother	☐	☐		
Sibling(s)	☐	☐		# sisters _____ # brothers _____
Aunt	☐	☐		
Uncle	☐	☐		
Children(Please List Below)				
	☐	☐		
	☐	☐		

Your Social History/Personal Environment (Circle if Applicable)

Order Referrals as appropriate (social worker, dietician)

What is your marital status?	☐Single ☐Married ☐Divorced ☐Widower ☐Other
What is your occupation?	
Transportation Needs?	☐Drives Independently / Adequate Transportation for Visits ☐Will Require Transport Assist
Transport:	☐Utilizes Transport by Public Transport ☐Teleride ☐Medicaid Transport
Support System?	☐Alone ☐Assisted Living ☐No Support System ☐Incarcerated ☐Homeless ☐Nursing Home ☐Lives with Others
Have you recently traveled out of country?	Y / N If yes, where and when?
What is your highest level of education completed?	
Primary Language:	

Smoking History

Currently every day smoker? Y / N	How many packs per day?
Currently some days smoker? Y / N	Do you use other tobacco products? ☐Chewing Tobacco ☐Snuff ☐Cigars ☐Pipe ☐Other
How many years? _____ Packs per day? _____	Do you use recreational drugs? Y / N If yes, please list:
Previous smoker, but quit: Y / N	
Number of years quit?	
Heavy smoker _____packs per day	
Light smoker _____packs per day	

*** Heavy Smoker = > ½ pack per day**
*** Light Smoker = < ½ pack per day**

Alcohol Consumption

Current every day drinker Y / N	How many days a week do you drink? _____
Current someday drinker Y / N	How many drinks a day do you drink? _____
Quit Y / N	How many years since you quit? _____
Never ☐	Current status unknown ☐

Have you been exposed to Hazardous Materials? Y / N
☐Asbestos ☐Benzene ☐Chemotherapy ☐Lead ☐Other Petroleum Products ☐Pesticides ☐Agent Orange
☐Radiation / Radiation Therapy, if so where _____

Infectious Diseases/Medical Devices

Infectious	Yes	Date/Month/Year	Medical Devices	Yes	Month/Date/Year

Diseases					
AIDS/HIV	☐		Central Line Catheter (PortaCath,Groshong,Hickman,PICC)	☐	
Hepatitis	☐		Dialysis Catheter	☐	
MRSA	☐		Urinary Catheter	☐	
VRE	☐		Drain Type: Site:	☐	
HPV	☐				
STD	☐				

Your Activities

Activities	Y / N	Description
Sedentary (No Physical Activity)	Y / N	
Daily Activities (Bathing, Dressing, etc.)	Y / N	
Occasional Exercise (Less than weekly exercise)	Y / N	
Light Exercise (1-2 x per week)	Y / N	
Regular Exercise (3-4 x per week)	Y / N	
Extensive Exercise	Y / N	
ADL's (Activities of Daily Living)	**Y / N**	**Description**
Can Do Myself	Y / N	
Need Help	Y / N	
Bedridden	Y / N	
Assistive Devices (Check if applicable)	Y / N	☐Crutches ☐Wheelchair ☐Cane ☐Walker
Hobbies	Y / N	
Sexually Active	Y / N	

Nutrition

Cancer Center Nutritionist (Dietician) referral by RN at initial visit if five or more nutritional/diet symptoms are identified.

Nutrition	Y / N	Description
Regular Meals	Y / N	
Nutritional Supplements	Y / N	
Liquid Diet	Y / N	
Vegetarian Diet	Y / N	
Diabetic Diet	Y / N	
Tube Feeding	Y / N	
Nutrition by Vein	Y / N	
Nausea/Vomiting	Y / N	
Diarrhea	Y / N	
Constipation	Y / N	
Taste/Smell Changes	Y / N	
Swallowing Difficulty	Y / N	
Problems Chewing or Dentures Don't Fit	Y / N	
Decreased Appetite	Y / N	
Mouth Sores	Y / N	
Increased Appetite	Y / N	
Dry Mouth	Y / N	
Feeling Full Quickly	Y / N	
Weight Loss	Y / N	

Allergies

Do you have any allergies?	Y/ N	Type of Reaction

Bees	Y / N	
Dairy	Y / N	
Gluten	Y / N	
Iodine	Y / N	
MSG	Y / N	
Peanuts	Y / N	
Penicillin	Y / N	
Pollen	Y / N	
Shellfish	Y / N	
Sulfa	Y / N	
Tree Nuts	Y / N	
Other:	Y / N	

Your Current Medications/Herbal Supplements

Medication/Supplement Name	Dose/# of Tablets	How Often?	When Started? Date/Year	Reason for Medication

Preferred Pharmacy/Location:_____ **Phone #:**_____

Preferred Mail Order Pharmacy:_____ **Phone #:**_____

Preferred Lab:_____ **Preference required by Insurance?**_____

Any Additional

Information:_____

Nancy N. and J.C. Lewis Cancer & Research Pavilion at St. Joseph's/Candler

Nancy N. and J.C.
Lewis Cancer & Research Pavilion
225 Candler Dr, Savannah GA 31405

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance officer in person at 5353 Reynolds Ave, Savannah, GA 31405 or by phone at 912-819-5291.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Notice was published and became effective on/of before September 01, 2013 and revised on June 01, 2015.

This Notice of Privacy Practices applies to the following organizations.

Nancy N. & J.C. Lewis Cancer and Research Pavilion
St. Joseph's | Candler Oncology Services
St. Joseph's | Candler - SC Cancer Specialists
Candler Medical Oncology Practice

St. Joseph's | Candler HIPAA Compliance and Privacy Officer 912-819-5291