ONCURA HEALTH
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REGISTRATION PACKET

Welcome to Oncura Health. We want to thank you for entrusting us for 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 will do everything they can to help you through this process.

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

- Page 0: Explanation of Paperwork (This Page)
- Page 1: Patient Registration & Demographics
- Page 2-3: Review of Systems, Reproductive & Preventative Health History
- Page 4: Personal Medical History, Social History, Hospitalization History
- Page 5: Vaccination History, Advance Directives, & PHQ-2
- Page 6: Family Health History
- Page 7: Medication & Allergy List
- Page 8-9: Authorization for Release of Health Information
- Page 10-11: 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.

As a service to you, we provide registration and verification of insurance and assistance with payment arrangements, if needed. We work extensively with insurance companies to have claims paid at their maximum benefit to keep your financial burden to a minimum.

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

A repeated pattern of no shows and/or canceled appointments may result in termination of the provider/patient relationship. Additionally, we may charge a fee for not showing up to a scheduled appointment. If you need to reschedule, please do so at least 24 hours in advance.

Please arrive at our office 30 minutes early for your first scheduled appointment to allow ample registration time. Please be advised that there could be additional forms that will need to be completed upon your arrival.

A surgical mask must be worn at all times during the duration of your visit (no cloth masks). We do allow for a maximum of one guest per patient, and this guest is required to adhere to our mask regulations as well.

If you have any questions concerning the above information, please do not hesitate to contact us.

Please indicate that you have read the above information.

Signature: _____ Today's Date: ____/_____/_____

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NEW PATIENT REGISTRATION

PATIENT ID

Patient Name (First, Middle, Last): _____

Preferred Name: _____ 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

Date of Birth: ____/____/_____ Age:___ SSN:_____ Marital Status:_____

Primary Language:_____ Secondary Language:_____

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

Yelp, Google, Website, Social Media, Print Ad, Drive By, MD or Patient Referral, Insurance Referral, Other

MD Referral:_____ Patient Referral: _____ Other:_____

EMERGENCY CONTACT

Name: _____ Relationship:_____ Phone:_____

PRIMARY CARE PHYSICIAN

MD Name: _____ Phone:_____ FAX:_____

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 Los Angeles Hematology-Oncology Medical group with my current insurance carrier as reflected above.

Signature: _____ Date:_____ Employee Initials:_____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

Address: _____ City:_____ Zip:_____ State:____

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REVIEW OF SYSTEMS

NEW PATIENT QUESTIONNAIRE

Name: _____ D.O.B.___/___/_____ Date Completed:_____

Dear Patient,

To ensure optimal care for you, we need to understand your complete health status and health history. With this goal in mind, we appreciate you spending 10-20 minutes completing this comprehensive health questionnaire as accurately as possible.

REVIEW OF SYSTEMS

For the Review of Systems, please indicate "Yes" if you are currently experiencing the symptom or if you have experienced the symptom within the past three months.

Please fill in the appropriate bubble completely. For example ⍰ Yes ⍰ No

General/Constitutional

Anorexia .....⍰ Yes ⍰ No
Fatigue/Weakness .....⍰ Yes ⍰ No
Weight Loss .....⍰ Yes ⍰ No
Fever .....⍰ Yes ⍰ No
Sweats/Night Sweats .....⍰ Yes ⍰ No
Hot Flashes .....⍰ Yes ⍰ No

Neurological

Headache .....⍰ Yes ⍰ No
Neuropathy .....⍰ Yes ⍰ No
Dizziness .....⍰ Yes ⍰ No
Confusion .....⍰ Yes ⍰ No

Ears, Nose, Throat, Mouth

Hearing Loss .....⍰ Yes ⍰ No
Mouth Sores .....⍰ Yes ⍰ No
Dry Mouth.....⍰ Yes ⍰ No

Eyes

Blurred Vision .....⍰ Yes ⍰ No
Excessive Tearing .....⍰ Yes ⍰ No
Dry Eyes .....⍰ Yes ⍰ No

Cardiovascular

Chest Pain.....⍰ Yes ⍰ No
Palpitations .....⍰ Yes ⍰ No
Swelling of Legs .....⍰ Yes ⍰ No

Respiratory

Shortness of Breath.....⍰ Yes ⍰ No
Shortness of Breath at rest.....⍰ Yes ⍰ No
Shortness of Breath with exertion ....⍰ Yes ⍰ No
Cough .....⍰ Yes ⍰ No
Chest Pain.....⍰ Yes ⍰ No

Gastrointestinal

Abdominal Pain.....⍰ Yes ⍰ No
Nausea.....⍰ Yes ⍰ No
Vomiting.....⍰ Yes ⍰ No
Diarrhea .....⍰ Yes ⍰ No
Constipation .....⍰ Yes ⍰ No
Blood in Stool .....⍰ Yes ⍰ No
Heartburn.....⍰ Yes ⍰ No

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REVIEW OF SYSTEMS

Musculoskeletal

Bone Pain.....☐ Yes ☐ No
Joint Pain.....☐ Yes ☐ No
Back Pain .....☐ Yes ☐ No

Integumentary (Skin)

Rash .....☐ Yes ☐ No
Itching.....☐ Yes ☐ No

Endocrine

Cold Intolerance.....☐ Yes ☐ No
Heat Intolerance.....☐ Yes ☐ No

Hematologic/Lymphatics

Excessive or Spontaneous Bruising ☐ Yes ☐ No
Excessive or Spontaneous Bleeding ☐ Yes ☐ No
Enlarged Lymph Nodes.....☐ Yes ☐ No

Fatigue Rating 0 1 2 3 4 5 6 7 8 9 10

Anxiety & Depression

Anxiety.....☐ Yes ☐ No
Depression.....☐ Yes ☐ No
Difficulty Sleeping.....☐ Yes ☐ No

REPRODUCTIVE HISTORY

(Female)

Age of 1st Menstrual Period: _____ Date of Last Menstrual Period: _____

Birth Control Pills Used? ☐ Y ☐ N ☐ Other Hormone: _____

Replacement Therapy Used? ☐ Y ☐ N **If Yes, how many years?** _____

Total Pregnancies: _____ Age at 1st pregnancy: _____ Number of Live Births: _____

Number of Miscarriages: _____ Number of Abortions: _____ Number of C-Sections: _____

Number of Ectopic Pregnancies: _____ Age of Menopause: _____

☐ Hysterectomy Bilateral ☐ Salpingo-oophorectomy ☐ Tubal Ligation

☐ Other sterilization procedure _____

(Male)

☐ Orchiectomy ☐ Vasectomy ☐ Other sterilization procedure _____

Contraceptives? ☐ Former ☐ Current ☐ Never

☐ Abstinence ☐ Condoms ☐ Rhythm method ☐ Other _____

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

Pap Smear: _____ Mammogram: _____ Colonoscopy: _____

Bone Density: _____ Cholesterol: _____

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MEDICAL HISTORY

MEDICAL HISTORY

– Please indicate if you have ever been diagnosed with or treated for any of the following conditions:

Asthma..... ☐ Yes
Bronchitits..... ☐ Yes
Hyperthyroidism..... ☐ Yes
Hypothyroidism..... ☐ Yes
Tuberculosis..... ☐ Yes
Thrombosis/Blood Clots..... ☐ Yes
Varicose Veins..... ☐ Yes
Diabetes, Type I (Insulin Dependent)..... ☐ Yes
Diabetes, Type II (Non-Insulin Dependent)..... ☐ Yes
Heart Murmur..... ☐ Yes
Hypercholesterolemia/High Cholesterol ..... ☐ Yes
Hypertension/High Blood Pressure..... ☐ Yes
Coronary Artery Disease/Angina..... ☐ Yes
Abnormal Pap Smear..... ☐ Yes
Abnormal Uterine Bleeding..... ☐ Yes
Arthritis..... ☐ Yes
Rheumatoid Arthritis..... ☐ Yes
Schizophrenia..... ☐ Yes
Depression/Mania/Bipolar..... ☐ Yes
Neurologic Disorder..... ☐ Yes
Anxiety Disorder/Panic..... ☐ Yes
Carpal Tunnel..... ☐ Yes
Sleep Apnea..... ☐ Yes
Kidney Stones..... ☐ Yes
Kidney Disease..... ☐ Yes
Autoimmune Disorder..... ☐ Yes
HIV/AIDS..... ☐ Yes
Lupus..... ☐ Yes
Hepatitis B..... ☐ Yes
Hepatitis C..... ☐ Yes
Mitral Valve Prolapse..... ☐ Yes
Osteoporosis..... ☐ Yes
Gout ..... ☐ Yes
Multiple Sclerosis..... ☐ Yes
Alcohol Abuse..... ☐ Yes
Drug Abuse..... ☐ Yes
Other Diagnosed..... ☐ Yes
List here: _____

SOCIAL HISTORY

Alcohol Consumption

Frequency:
☐ Less than 1 drink per week, ☐ 2-3 drinks per week, ☐ 1 drink per day, ☐ 2-3 per day, ☐ 3+ per day

Tobacco Use

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? _____

HOSPITALIZATIONS & SURGERIES

Month & Year	Reason for Surgery

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MEDICAL HISTORY & DIRECTIVES

VACCINATION HISTORY

Vaccination	Date last received
Covid-19 Vaccine– please indicate which vaccine (J&J, Pfizer, or Moderna)	
Influenza (Flu) Vaccine	
Pneumococcal Vaccine (for pneumonia)	
Hepatitis Vaccine	
HIV Vaccine	
Any other vaccination notes	

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**? If yes, please provide a copy. ☐ Yes ☐ No ☐ Unknown ☐ Would like to learn more

Do you have **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) **If yes, please provide a copy to the front desk or provider**.

☐ Yes ☐ No ☐ Unknown ☐ Would like to learn more

Do you have a next of kin or **person who will make decisions for you** if needed? ☐ Yes ☐ No ☐ Unknown

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) ☐ Unknown

PATIENT HEALTH QUETIONNAIRE-2 (PHQ-2)

Over the **last two weeks**, how often have you been bothered by the following problems? Circle your answer.

Little interest or pleasure in doing things
Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐

Feeling down, depressed, or hopeless
Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐

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FAMILY HEALTH HISTORY

FAMILY HISTORY - Age at which family member was diagnosed

	Family Members	Status (A/D/U) Alive, Deceased, Unknown	Breast Cancer	Ovian Cancer	Uterine Cancer	Colon Cancer	Prostate Cancer	Stomach Cancer	Pancreatic Cancer	Melanoma	Heart Disease	High Blood Pressure	Diabetes	Other
	Example	*A*	*62*										*51*	*Lymphoma (68)*
Paternal Family	**Father**			*N/A*	*N/A*									
	Grandfather			*N/A*	*N/A*									
	Grandmother						*N/A*							
	Aunt						*N/A*							
	Uncle			*N/A*	*N/A*									
Maternal Family	**Mother**						*N/A*							
	Grandfather			*N/A*	*N/A*									
	Grandmother						*N/A*							
	Aunt						*N/A*							
	Uncle			*N/A*	*N/A*									
Personal	**Self**													
	Sister						*N/A*							
	Brother			*N/A*	*N/A*									

Other family health history notes:

_____

_____

_____

_____

_____

_____

_____

_____

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MEDICATION & ALLERGY LIST

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

Name	Strength	Qty	Frequency	Start Date	End Date

ALLERGIES

Substance	Reaction

Any additional notes you would like to share with your doctor:

_____

_____

_____

_____