PATIENT REGISTRATION

Associated Medical Specialists, P.A. d/b/a Coastal Cancer Center ("CCC")

Date: _____ Chart # _____ Initial _____

Name _____ Sex (circle) M F

Date of Birth _____ Age _____ Social Security # _____

Marital Status (circle) Married Single Widowed Divorced **Ethnicity** (circle) Hispanic/Latino **NOT** Hispanic/Latino

Race (circle) American Indian or Alaska Native Asian Black or African American White

Preferred Language: English _____ Other _____

Mailing Address (No Po Box) _____

City/State/Zip + 4 _____

Phone: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Email Address _____ Or Not Applicable ☐

Preferred Contact Number: Home ☐ Cell ☐

Employment Status (Circle) 1-Full-time 2-Part-time 3-Not Employed 4-Self 5-Retired 6-Active Duty

Occupation _____ Employer Name _____ Phone ( ) _____

Employer Address _____ City/State/Zip + 4 _____

Disabled? _____ Year _____ Due To _____

Guarantor Information

Guarantor Name _____ Phone: Home ( ) _____ Work ( ) _____

Address (if different from Patient's) _____ City/State/Zip + 4 _____

Social Security Number _____ Date of Birth _____

Insurance Information

Primary Insurance _____ Name of Subscriber *(if not patient) _____

Secondary Insurance _____ Name of Subscriber *(if not patient) _____

Please complete only if subscriber on any policy is other than you, the patient

Subscriber Name _____ Subscriber Date of Birth _____ Subscriber Social Security # _____

Relationship of Patient to Subscriber (please circle) Self Spouse Child Other: _____

Subscriber Occupation _____ Subscriber Employer _____

Subscriber Employer Address _____ City/State/Zip + 4 _____

Subscriber Work Phone ( ) _____

Name _____ Chart number: _____

CCC charges the Patient for all services it renders, regardless of insurance coverage. Please provide all insurance cards to the registrar upon arrival. A copy of insurance cards will be kept which makes it imperative for you, as the Patient, to inform us of a change in your coverage, work or other financial matters, as soon as it becomes known to you. Medicare, Medicaid and contracted insurers claims will be filed by this office. All other insurance claims are the responsibility of the Patient. Any assistance completing the forms may be offered as needed. Payment is expected for all services when rendered, unless previous arrangements in writing have been agreed upon.

GUARANTEE OF PAYMENT

In consideration for services, the patient and any Guarantor individually guarantee payment of all services provided to the Patient by CCC. This obligation of payment extends to all charges not paid by the Patient's insurance company or, if available, Medicare as stated below. By voluntarily signing this Guarantee, the Patient and Guarantor each agree to the payment of any outstanding charges and expenses arising from all services provided to the Patient. If the applicable insurance company does not pay within 30 days after any payment is due, payment is due from the Patient or Guarantor.

_____ _____

SIGNATURE DATE

_____ _____

SPOUSE DATE

MEDICARE PATIENTS

Medicare policies have a coinsurance and deductible. If Patient does not have supplemental coverage that covers coinsurance and deductible or if Patient has signed an Advance Beneficiary Notice, Patient agrees to be personally and fully responsible for payment. Patient requests that payment of authorized Medicare benefits be paid to CCC for services furnished. Patient authorizes CCC to release to the Centers for Medicare and Medicaid services or its agents, any information needed to determine these benefits or the benefits payable for related services.

_____ _____

SIGNATURE DATE

_____ _____

SPOUSE DATE

INSURANCE ASSIGNMENT AND AUTHORIZATION AND RELEASE AUTHORIZATION

In order to submit a claim for payment for services covered by a policy or program, such as Medicare, we must have your authorization to release medical information. I (Patient) authorize the release of any medical information relating to my charges with CCC. I authorize CCC to act in my behalf as authorized representative: (1) in the collection of benefits from any responsible third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to myself and/or participant or insured. I request and authorize that benefit payment be made directly to CCC. Furthermore, I designate CCC as my authorized representative and authorize CCC to act on my behalf to (1) request and receive a copy of the summary plan description; (2) pursue a benefit claim and/or (3) appeal an adverse benefit determination. I understand that I am responsible for payment of my medical charges regardless of the status of any claim.

_____ _____

SIGNATURE (Patient) DATE

_____ _____

SIGNATURE (Guarantor) DATE

CONSENT TO TREAT

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I authorize the use and disclosure of my personal health information for the purposes of treatment and healthcare operations. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____ _____

SIGNATURE DATE

_____ _____

COASTAL CANCER CENTER WITNESS DATE

Date _____/_____/_____

COASTAL CANCER CENTER

A division of Associated Medical Specialists, PA

Mailing Address : 8121 ROURK STREET
MYRTLE BEACH, SOUTH CAROLINA 29572
(843) 692-5000

Chart#: _____

817 Farrar Dr
Conway, Sc 29526
(843) 234-1660

3008 Bayboro St
Loris, SC 29569
(843) 756-0932

4620 Hwy 17
Murrells Inlet, SC 29576
(843) 357-7357

PATIENT MEDICAL HISTORY FORM

Last Name _____ First Name: _____ MI:_____ Date of Birth: _/___/___ Age:_____

Do you have an advance directive (living will)? Yes _____ No ____ If yes, please provide a copy.

Local pharmacy: _____ Phone number: _____

Primary care physician

(Frist & Last Name): _____ Referring physician: _____

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS: What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

Please answer the following questions about your present medical problem as it applies to you.

Cancer Pain Severity (If applies)
If pain is present, circle the number that best describes the level of pain with 4 being the most severe.

0 None
1 Mild pain not interfering with function.
2 Moderate pain; pain or analgesics interfering with function, but not interfering with activities of daily living.
3 Severe pain; pain or analgesics severely interfering activities of daily living.
4 Disabling pain.

Location
☐ Abdomen ☐ Back ☐ Breast ☐ Extremity
☐ Chest ☐ Head/Neck
Other _____

Duration
When did you first notice the problem?
Other _____

Modifying Factors
Does anything help or make the problem worse?
Moving around? Standing up? Lying on my side?
Other _____

Timing
How long does the problem last?

_____

_____

Associated Signs/Symptoms
Is anything else occurring at the same time? Please explain.

_____

_____

_____

Context
Is the problem constant or variable?
Dull then Sharp? Very sharp then leaves? Always there?

_____

Quality
Does the problem interfere with your normal functions?
Yes ☐ No ☐ If yes, please explain

_____

PAST MEDICAL HISTORY: Please circle and list dates if you have had any of the following:

			Date:
Cancer	Y	N	_____
Lymphoma	Y	N	_____
Leukemia	Y	N	_____
Blood Problem	Y	N	_____
Connective Tissue Disease	Y	N	_____
Arthritis	Y	N	_____
Thyroid Problem	Y	N	_____
High Cholesterol	Y	N	_____

Other _____

			Date:
Diabetes	Y	N	_____
Kidney Disease	Y	N	_____
Tuberculosis	Y	N	_____
Appendix Removal	Y	N	_____
Asthma	Y	N	_____
Heart Disease	Y	N	_____
High Blood Pressure	Y	N	_____
Lung Disease	Y	N	_____

Other _____

Patient Name: _____ Chart #_____

Please list all prior hospitalization and surgery. Please do not list any pregnancies and/or births

	#1	#2	#3
Reason for admission (Medical reasons or diagnosis)			
Month and year hospitalized			
Type of Surgery (if one was done)			

Have you EVER received radiation treatment for any illness? Yes No

If yes, for what illness? _____

When was the treatment received? _____

Have you EVER received chemotherapy treatment for any illness? Yes No

If yes, for what illness? _____

When was the treatment received? _____

MEDICATIONS:

List all medications, or drugs you currently use or have used at home within the last three months. Include those with a prescription from a doctor, those you bought over the counter in a store, any you received from a friend, any vitamins, home remedies, laxatives or any other product you take to improve your health. If you do not know all this information, please bring all the bottles or boxes with you to your next office visit. (Please attach an additional page if you need more space)

	Name & Strength of Medication	Amount taken	Approximate date Started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES:

List anything (drugs, food, insects, pollens, etc.) you are **allergic** to:

	Item	Describe reaction you had
1.		
2.		
3.		
4.		

FOR WOMEN ONLY

Are you currently menstruating? Yes No

If yes, when did your last menstrual period begin? DATE _____/_____/_____

If you are post-menopausal, give approximate date. DATE _____/_____/_____

Please provide the following information:

Number of children born alive _____

Number of miscarriages _____

Are you on hormone replacement therapy? Yes No

Do you have abnormal vaginal bleeding? Yes No

Patient Name: _____ Chart #_____

The following questions are about your **FAMILY**, you may not know all the information asked. Please answer to the best of your ability.

Please add additional information on the last page.

	NAME	LIVING	DEAD	PRESENT AGE OR AGE AT DEATH	HEALTH PROBLEMS	CAUSE OF DEATH IF DECEASED
Mother		☐	☐			
Father		☐	☐			
Brother		☐	☐			
Brother		☐	☐			
Brother		☐	☐			
Sister		☐	☐			
Sister		☐	☐			
Sister		☐	☐			

CHILDREN:	NAME	LIVING	DEAD	PRESENT AGE OR AGE AT DEATH	HEALTH PROBLEMS	CAUSE OF DEATH IF DECEASED
First		☐	☐			
Second		☐	☐			
Third		☐	☐			
Fourth		☐	☐			
Fifth		☐	☐			

Any history of cancer, leukemia or lymphoma in your family? If so, give details: _____

_____

_____

_____

SOCIAL HISTORY:

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

What is/was your job position?_____

What was your last grade completed in school? _____

What are your hobbies? _____

Have you EVER smoked? ☐ Yes ☐ No

Do you now smoke? ☐ Yes ☐ No

If you have smoked average packs per day _____

Number of years smoked _____

Date stopped _____ Do you desire counseling for smoking cessation? ☐ Yes ☐ No
If yes, please speak with your nursing staff.

Do you consume alcoholic drinks? ☐ Yes ☐ No

Amount: ☐ Never ☐ Rarely ☐ Moderately ☐ Socially ☐ Frequently ☐ Excessively

Do you now or have you ever had a problem with alcoholism or drug addiction? _____

If you are of reproductive age (generally females age 18-40 and males age 18-50), do you desire to address fertility in regard to your diagnosis and treatment options? ☐ Yes ☐ No If yes, please speak with your nursing staff.

Patient Name: _____ Chart #: _____

Review of Systems: Do you **CURRENTLY** have or are you **NOW** bothered with the following symptoms? Circle Yes or No

Constitutional Symptoms			**Cardiovascular**		
Fever	Y	N	Heart pain (Angina)	Y	N
Chills	Y	N	Irregular heart rhythm	Y	N
Fatigue/Excessively tired	Y	N	Congestive heart failure	Y	N
Weight loss	Y	N	Varicose veins	Y	N
			Extremity swelling	Y	N
Allergic/Immunologic			**Gastrointestinal**		
Seasonal allergies	Y	N	Nausea	Y	N
Food allergies	Y	N	Vomiting	Y	N
IV contrast allergies	Y	N	Diarrhea	Y	N
Drug allergies	Y	N	Constipation	Y	N
Eyes			Abdominal pain	Y	N
Sudden visual changes	Y	N	Abdominal swelling	Y	N
Excessive tearing	Y	N	Loss of appetite	Y	N
Eye irritation	Y	N	Indigestion/heartburn	Y	N
Double vision/Blurred vision	Y	N	Blood in bowel movement	Y	N
Ear/Nose/Throat/Mouth			**Genitourinary**		
Hearing difficulty	Y	N	Blood in urine	Y	N
Dry mouth	Y	N	Painful urination	Y	N
Mouth irritation	Y	N	Frequent urination	Y	N
Sore throat/Hoarseness	Y	N	Hesitation on urination	Y	N
Difficulty Swallowing	Y	N	Incontinence	Y	N
Ear discomfort	Y	N	Sexual dysfunction	Y	N
Sinus problem	Y	N	Genital Mass/tenderness	Y	N
Ringing in the ears	Y	N			
Endocrine			**Musculoskeletal**		
Hot flashes	Y	N	Joint pain	Y	N
Sweats	Y	N	Swelling/edema	Y	N
Heat intolerance	Y	N	Muscle aches	Y	N
Cold intolerance	Y	N	Bone pain	Y	N
Excessive Thirst	Y	N	Decreased range of motion	Y	N
Hematological/Lymphatic			**Integumentary**		
Easy bruising	Y	N	Skin rash	Y	N
Easy bleeding	Y	N	Lesions	Y	N
Tender lymph nodes	Y	N	Skin breakdown	Y	N
Swollen lymph nodes	Y	N	Persistent itch	Y	N
Breasts			**Neurological**		
Abnormal breast mass	Y	N	Headaches	Y	N
Nipple Discharge	Y	N	Dizzy spells	Y	N
Nipple pain	Y	N	Numbness/tingling	Y	N
			Weakness	Y	N
			Unsteady balance when walking	Y	N
			Tremor	Y	N
Respiratory			**Psychological**		
Wheezing	Y	N	Are you generally satisfied with your life?	Y	N
Persistent cough	Y	N	Do you feel nervous or anxious?	Y	N
Sputum production	Y	N	Do you have trouble sleeping?	Y	N
Shortness of breath	Y	N	Do you have periods of extreme sadness or crying?	Y	N
Chest pain on breathing	Y	N			
Coughing up blood	Y	N			

Patient Signature Date

Physician Signature Date

ASSOCIATED MEDICAL SPECIALISTS, PA d/b/a COASTAL CANCER CENTER, ("CCC")
PORTAL AND/OR EMAIL COMMUNICATION CONSENT
contactus@coastalcancercenter.com

Patient Name: _____ Chart No.: _____

****

Request for SECURE PATIENT PORTAL:

Patient is: ☐ Accepting Patient Portal OR ☐ Declining Patient Portal

_____ _____

Signature of Patient or Personal Representative Date

Email Address: _____

Request for EMAIL USE:

Patient is: ☐ Accepting Email use OR ☐ Declining Email use

I request that CCC communicate by email with me as needed for my/the patient's medical care. I have read, understand and agree to the terms for using email to communicate health information. I understand that:

1. By law, CCC cannot use or share my health information without my permission except as listed in CCC' s Notice of Privacy Practices.
2. CCC cannot promise security and confidentiality when emailing. CCC is not responsible if emails are incorrectly shared and someone other than CCC is at fault.
3. I can cancel this email consent at any time. I must cancel in writing and address it to the person or organization named above. I cannot cancel information already shared.
4. I do not have to sign this form. My refusal will not change this permission with respect to my ability to get treatment, payment for treatment, or benefits. I understand that I will not be able to communicate by email with CCC if I do not sign this form.
5. Once information is sent to me by email, it may not be protected by law and someone may be able to share my information with others without my permission.
6. This request expires at the request of the patient or legal representative.

Risks and Conditions of Using Email:

- Email should **not** be used for emergencies, issues that must be handled quickly, or Information that is particularly sensitive to you.
- Email may not be delivered and CCC is not responsible for lost or misdirected email.
- Staff other than doctors or nurses may process and read emails sent to CCC.
- It is up to you to call CCC if your email is not answered or if additional follow-up is needed.
- You must tell us why you are emailing in the subject line of the message. Examples include: medication refill, need an appointment or need a referral. **If you do not list a subject, your message will be deleted without being read.**
- The message must include the patient's name, telephone number and date of birth.
- You are in control of emails sent to you by CCC. CCC is not responsible if you let someone else see your emails.
- CCC can change the terms of, or stop emailing, at any time. You will be told if this happens.

_____ _____

Signature of Patient or Personal Representative Date

Email Address: _____

Description of Personal Representative's Authority: _____

CCC Witness _____ SCAN in iKM _____

Revised 10/25/18

Associated Medical Specialists, PA, d/b/a Coastal Cancer Center
Authorization for Release of Information to Family and/or Friends

Patient Name: _____ Chart No.: _____

Associated Medical Specialists, PA, d/b/a/ Coastal Cancer Center is authorized to release protected health information about the above named patient to the authorized people named below. This will enable Coastal Cancer Center to best coordinate your healthcare. **Please circle the information each person may receive and/or if emergency contact:**

Print name	**Relationship/Phone #**	
_____		**CLINICAL APPOINTMENT FINANCIAL EMERGENCY**
_____		**CLINICAL APPOINTMENT FINANCIAL EMERGENCY**
_____		**CLINICAL APPOINTMENT FINANCIAL EMERGENCY**

If you (**the patient**) have an answering machine or voice mail, may we leave a message regarding the following? **Y N**

Please circle each one signifying your consent **CLINICAL APPOINTMENT FINANCIAL**

Preferred method of contact for appointment reminders: **Text Phone Email**

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by contacting Coastal Cancer Center, and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.
This authorization shall be in effect until revoked by the patient or the patient's representative.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

_____ _____
Coastal Cancer Center Witness Date

Associated Medical Specialists, PA
d/b/a Coastal Cancer Center

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Chart No. _____

I have received a copy of the Notice of Privacy Practices from the above named practice.

_____ _____
Patient or Personal Representative Signature Date

_____ _____
Coastal Cancer Center Witness Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____ An emergency existed & a signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

_____ Unable to communicate with the patient for the following reason: _____

_____

_____ Other: _____

_____

Coastal Cancer Center printed name: _____

Signature: _____

Date: _____

Revised: 06/17/14