NORTH DALLAS
RADIATION ONCOLOGY CENTER
NDROC

5948 W. Parker Rd, Suite 100
Plano, TX 75093
Phone (972) 378-4114
Fax (972) 473-7204

Patient Registration Form

Today's Date:_____
Social Security #:_____
First Name _____Middle _____
Last Name_____
Sex: M F Date of Birth: _____
Marital Status _____
Referring Physician _____

Home Address _____
_____
City _____ State _____ Zip _____
Home Phone (_____)_____
Work/Cell Phone (_____)_____
Circle One: Employed Retired Full-Time Student
Employer_____

Insurance Information

Primary Insurance Coverage

Insurance Name: _____ Policyholder's Name: _____
Relationship to policyholder: ___Self ___Spouse ___Child ___Parent ___Other: _____
Policyholder's Employer: _____ Policyholder's Date of Birth: _____

Secondary Insurance Coverage

Insurance Name: _____ Policyholder's Name: _____
Relationship to policyholder: ___Self ___Spouse ___Child ___Parent ___Other: _____
Policyholder's Employer: _____ Policyholder's Date of Birth: _____

Emergency Contact

Name: _____ Relationship: _____
Home Phone: (_____)_____ Work/Cell Phone: (_____)_____

Guarantor/Responsible Party (*if applicable*)

Full Name _____ Relationship: _____
Social Security #_____ Date of Birth:_____ Sex: M F
Home Phone (_____)_____ Work/Cell Phone (_____)_____
Home Address:_____

I certify that all of the above information is true and accurate, and will notify North Dallas Radiation Oncology Center of any changes as necessary.

Patient/Guardian Signature: _____ Today's Date: _____

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Provider Information

Referring Physician: _____

Address: _____

_____

Phone #: (_____)_____ Fax #: (_____)_____

Primary Physician: _____

Address: _____

_____

Phone #: (_____)_____ Fax #: (_____)_____

Medical Oncologist: _____

Address: _____

_____

Phone #: (_____)_____ Fax #: (_____)_____

Surgeon: _____

Address: _____

_____

Phone #: (_____)_____ Fax #: (_____)_____

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Patient History & System Review

Medical History

Have you ever had any of the following (circle Y or N):

Previous cancer?	Y	N	Horseshoe kidney?	Y	N
High blood pressure?	Y	N	Lupus/sclerodenna/		
Pacemaker?	Y	N	collagen vascular disease?	Y	N
Diabetes?	Y	N	Inflammatory bowel disease?	Y	N
Emphysema or COPD?	Y	N	Diverticulitis?	Y	N
Kidney loss/dysfunction?	Y	N			

Previous radiation therapy? Y N If yes, to which area of the body? _____

What facility? _____

When? _____

Chemotherapy? Y N If yes: _____PREVIOUS ____CURRENTLY ON TREATMENT

What facility? _____

When? _____

Previous Surgeries/Procedures

Type of Operation	Approximate Date	Type of Operation	Approximate Date
_____		_____	
_____		_____	
_____		_____	

Other illnesses and hospitalizations: _____

_____

_____

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Family History

	Type/Location of Cancer	Age Diagnosed		Type/Location of Cancer	Age Diagnosed
Father:			Sibling:		
Mother:			Sibling:		
Child:			Sibling:		

Social History

Do you drink alcohol? Y N If yes, average number of drinks per day: _____

Have you ever smoked cigarettes? Y N If yes, year began: _____ Year stopped: _____

Average # packs per day: _____ List other tobacco products used: _____

Current occupation: _____ # years: _____ Previous occupation: _____ # years: _____

Review of Systems

Have you developed any of the following symptoms during the past year (circle Y or N):

Weight loss?	Y	N	If yes, please explain: _____
Decreased appetite?	Y	N	If yes, please explain: _____
Nausea?	Y	N	If yes, please explain: _____
Fatigue?	Y	N	If yes, please explain: _____
Bone Pain?	Y	N	If yes, please explain: _____
Fever?	Y	N	If yes, please explain: _____
Cough?	Y	N	If yes, please explain: _____
Shortness of breath?	Y	N	If yes, please explain: _____
Swollen glands?	Y	N	If yes, please explain: _____
Headache?	Y	N	If yes, please explain: _____
Weakness?	Y	N	If yes, please explain: _____
Numbness/tingling?	Y	N	If yes, please explain: _____

_____

Patient Signature *Today's Date*

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Medication & Allergies

Patient Name: _____ D.O.B. _____

Drug Name	Dosage	Frequency

Please use the space provided below to tell us of any allergies you have.

Allergy	Reaction/Symptoms

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Financial Responsibility Agreement

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visit(s) to North Dallas Radiation Oncology Center and any non-affiliated company involved in my care. This includes medical services and visits, preventative exams and physicals, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make payment in full.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted/in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out of pocket expense to me. I agree to be financially responsible and make payment in full.

I understand and agree it is my responsibility to know if my Primary Care Physician (PCP) choice has been processed by my insurance company or plan. If I have requested a PCP change that has not processed by my insurance company, it may result in claims being denied, and I agree to be financially responsible and make payment in full.

_____

Patient/Guarantor Signature *Today's Date*

_____

Patient/Guarantor Printed Name

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Authorization for Use or Disclosure of Protected Health Information

By signing this form, I authorize North Dallas Radiation Oncology Center to use and disclose my Protected Health Information (PHI) in the following manner:

Share my Protected Health Information with:
(Please CIRCLE and INITIAL applicable authorization)

_____ my Spouse. Spouse's Name: _____

_____ my parent/siblings/child(ren)/guardian. Please provide applicable names: _____

_____

_____ the following person(s) _____

_____

_____ DO NOT DISCLOSE MY PHI WITH ANYONE

Disclose my protected health information for the following reasons:
(Please CIRCLE and INITIAL applicable authorization)

_____ to leave an appointment reminder on my answering machine/service

_____ at home _____ at work

_____ to communicate via email

_____ at home _____ at work

_____ to fax information/forms

_____ at home _____ at work

_____ DO NOT DISCLOSE MY PHI FOR ANY REASON STATED ABOVE

_____

Patient/Guarantor Signature *Today's Date*

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Patient Disclosures & Consents

Assignment of Insurance Benefits

I hereby authorize direct payment of my insurance benefits to North Dallas Radiation Oncology Center (NDROC) or the physician individually for services rendered to my authorized dependents or me. I understand and agree that I will be responsible for any co-pay or balance due that NDROC is unable to collect from my insurance carrier. Initial:_____

Medicare/Medicaid/Champus Benefits

I certify that the information I have given by applying for payment under these programs is correct. I authorize the release of any of my records that these programs may request. I hereby direct that payment of my authorized benefits be made directly to NDROC on my behalf. Initial:_____

Authorization to Release Non-Public Information

I hereby authorize NDROC or the physician to release medical or incidental, non-public, personal information that may be necessary for medical evaluation, treatment, consultation, or processing of insurance benefits. Initial:_____

Lab/X-Ray/Diagnostic Services

I understand that I may receive a *separate bill* from an entity (other than NDROC) if my medical care includes labs, x-rays, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance.

Initial:_____

I hereby consent to evaluation, testing, and treatment as directed by my physician, and affirm that I have read and agree with all disclosures on this form.

_____

Patient/Guarantor Signature *Today's Date*

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Telephone Consumer Protection Act Disclosure

With the increasing number of consumers eliminating land lines and conducting communications via cellular telephone, text message, facsimile or email, businesses must consider current and future compliance to regulations governing all means of consumer communications. Due to the modern methods available to communicate and contact consumers, the Telephone Consumer Protection Act continues to confront all industries.

Please list any cellular telephone numbers provided on your "Patient Registration Form":

_____

_____

Please initial one of the following:

_____ I authorize North Dallas Radiation Oncology Center, its affiliates, and contracted representatives to contact me at the number(s) specified above regarding financial matters (including but not limited to: insurance issues, account balance, and statements).

_____ I ***do not*** give authorization to North Dallas Radiation Oncology Center, its affiliates, or contracted representatives to contact me at the number(s) specified above regarding financial matters (including but not limited to: insurance issues, account balance, and statements).

**Please note, we must have at least one valid telephone number on file to contact you regarding the matters referenced in this form.*

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Printed Name of Patient/Guardian **Date**

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Acknowledgement of Review of Notice of Privacy Practice

I have reviewed NDROC's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at any time.

_____

Patient/Legal Guardian Signature *Today's Date*

_____

Patient/Legal Guardian Printed Name

If signed by legal guardian, please provide relationship to patient and contact information:

_____

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained due to:

- Individual refused to sign
- Communication barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other:_____

_____