



High Plains Oncology

REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is legal name?	(Former name):	Race:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Social Security no.:		Home phone no.: ()		Cell phone no.: ()		Email:	
Street Address/P.O. Box:			City:	State:	ZIP Code:		
Occupation:			Employer:	Employer phone no.: ()			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
Street Address/P.O. Box:	City:	State:	ZIP Code:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to High Plains Oncology physicians. I understand that I am financially responsible for any unpaid balance. I also authorize High Plains Oncology or the insurance company to release any information with respect to myself or my family required to process my claims.

Patient/Guardian signature

Date

Original Date:

Date Revised:

 **High Plains Oncology**
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed	
Primary Care Physician:	Other Physicians:	

PERSONAL HEALTH HISTORY

Please complete for any PRIOR cancer, radiation treatment, or chemotherapy

Prior Cancers:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	If yes: Year _____ Kind of Cancer _____
Prior Radiation Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	If yes: Year _____ Area Treated _____ Where _____
Prior or Current Chemotherapy:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	If yes: Year _____ Where _____

Surgeries

Date	Type of Operation	Hospital

Other hospitalizations

Date	Reason	Hospital

Are you on a clinical trial/experimental drug?

Yes No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, including vitamins and inhalers

Name of Drug	Dose	Frequency Taken	Length of time taken	Reason for taking

Pharmacy Name: _____

Pharmacy Phone Number: _____

Allergies to medications/food/other

Name the Drug/substance	Reaction You Had

SOCIAL HISTORY AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Work	Current Occupation:	# of years _____		
	Previous Occupation:	# of years _____		
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?	For how many years?		
	If you have quit drinking, how old were you when you quit?	_____ years old		
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or if quit: Year started _____ Year quit _____		
Personal Safety	Do you live alone?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have a Medical Power of Attorney for Health Care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	That person is: _____
	Did you bring either of these with you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A (If yes, copy in chart) Initials _____
	Do you want assistance in completing an Advanced Directive or Medical Power of Attorney?			<input type="checkbox"/> Yes <input type="checkbox"/> No

ARE YOU TAKING:

Glucophage / Metformin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coumadin / Warfarin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin / Non-Steroidal Anti-Inflammatory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please turn to next page

FAMILY HISTORY OF CANCER

	AGE DIAGNOSED	TYPE OR LOCATION OF CANCER		AGE DIAGNOSED	TYPE OR LOCATION OF CANCER
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F				

REVIEW OF SYMPTOMS

HAVE YOU DEVELOPED ANY OF THESE SYMPTOMS IN THE PAST YEAR:

Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Nausea	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Weight Loss	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Decreased Appetite	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Depressed	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bone Pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tired	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Back Pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Numbness / Tingling	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Blurred / Double Vision	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Headache	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hoarseness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Easy Bruising	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Shortness of Breath	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Swollen Glands	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cough	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Chest Pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other: _____	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

PAIN

Are you having any pain or discomfort? Yes No

Indicate how much pain by circling a number: **NO PAIN** 1 2 3 4 5 6 7 8 9 **SEVERE PAIN**

Where is your pain?

Describe your pain: Achy Burning Dull Stabbing Sharp Other: _____

What makes your pain better?

What makes your pain worse?

Amount of pain medication in a 24 hr period?

PAST MEDICAL HISTORY

Check if you have, or have had, any of these diagnoses:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema or COPD	<input type="checkbox"/> Lupus, Scleroderma, or collagen vascular disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes or sugar in urine	<input type="checkbox"/> Kidney loss, dysfunction, or abnormality	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Seizures	<input type="checkbox"/> Crohn's Disease or ulcerative colitis	<input type="checkbox"/> Post-Menopausal
<input type="checkbox"/> Stroke	<input type="checkbox"/> Could you be Pregnant	<input type="checkbox"/> Lactating
<input type="checkbox"/> Anemia	Last Menstrual Period _____	<input type="checkbox"/> Other: _____

Patient Record Disclosures

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also given the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE MARK ALL THAT APPLY):

- Home telephone: _____
 Leave a message with detailed information
 Leave a message with call-back number only
 Please **DO NOT** leave a message

- Written Communication
 Mail to my home address
 Mail to my work address
 Please **DO NOT** mail

- Work Telephone: _____
 Leave a message with detailed information
 Leave a message with call-back number only
 Please **DO NOT** leave a message

- The following people may have access to my medical information (PHI):
 Spouse/Sig. Other: _____

- Cell Number: _____
 Leave a message with detailed information
 Leave a message with call-back number only
 Please **DO NOT** leave a message

- Child: _____
 Child: _____
 Child: _____
 Other: _____
 Nobody should have access

- Fax Number: _____
 Please **DO NOT** fax any information to me

- Email: _____
 Please **DO NOT** email me

Patient Signature

Date

Print Name

Date of Birth

WHO DOES THIS NOTICE APPLY TO?

High Plains Oncology provides health care to our patients and clients in partnership with other professionals and organizations. The privacy practices in this notice will be followed by:

- Any High Plains Oncology (“the center”) health care professional authorized to enter information into your chart.
 - All departments and units of this center.
 - Any member of a volunteer group that is authorized by this center to help you.
 - All employees, staff and other personnel of the center.
- Any business associate with whom we share health information.

OUR RESPONSIBILITY TO YOU REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you is personal. We are committed to protecting the privacy of medical information about you. In an effort to provide the highest quality medical care and to comply with certain legal requirements, we will and are required to:

- Keep your medical information private.
- Provide you with a copy of this notice.
- Follow the terms of this notice.
- Notify you if we are unable to agree to a restriction that you have requested.
- Accommodate reasonable requests by you for us to communicate health information by alternative means or at alternative locations.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose medical information about you for your **treatment** (such as sending medical information about you to a specialist as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and **to support our health care operations** (such as comparing patient data to improved treatment methods).

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (TPO)

We will use your health information for treatment. For example: Information received by a nurse, physician or other member of your healthcare team will be recorded in your record

and used to determine your course of treatment. We will also provide your physician or a subsequent healthcare provider with copies of reports to assist him or her in treating you once you’re discharged.

We will use your health information for payment. For example: A bill may be sent to you or an insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used in your treatment.

We will use your health information for regular health care operations. For example: Members of the medical staff, the risk or quality management staff of the center may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

HOW WILL MY INFORMATION BE USED

- We may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you.
- We may contact you to solicit support for certain **fundraising activities**. *****You will have an opportunity to refuse or opt-out of receiving this information upon the first contact by us***.**

This information may be provided to members of the clergy, and except for religious affiliation, to other people who ask for you by name to include members of the media. *****If you would like to opt-out of being in the directory, please notify the admission staff***.**

- Family and Friends. We may release medical information about you to a family member, friend, or any other person involved in your medical care. We may also give information to those you identified as responsible for payment of your care.

We may use or disclose medical information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without your prior authorization for the following purposes:

- Research. We may use and disclose medical information about you for research purposes. All research projects are subject to a special approval process through the appropriate committee.
- Law. We may disclose medical information when required by law, such as in response to a request from law enforcement in

specific circumstances or in response to valid judicial or administrative orders.

- Public health. We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc. as required by law.
- Business associates. There are some services provided in our organization through contracts with business associates (ie. we may disclose medical information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the health care services we provide). To protect your health information we require the business associate to appropriately safeguard your information.
- Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
- Funeral directors. We may disclose health information to funeral directors consistent with applicable law for them to carry out their duties.
- Organ donation. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities for the purpose of tissue donation and transplant.
- Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events.
- Workers’ Compensation. We may disclose health information necessary to comply with laws relating to Workers’ Compensation or other similar programs established by law.
- Correctional institution. Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of other individuals.
- State Requirements. Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.
- Organized Health Care Arrangements. The center and its medical staff members have organized and are jointly presenting this notice to you. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment this time.

OTHER USES OF MEDICAL INFORMATION

In any other situation not covered by this notice, we will ask you for your written authorization before using or disclosing medical information about you. If you choose to authorize us to use or disclose your health information, you can later revoke that authorization by notifying us in writing of your decision, except to the extent that action has already been taken by us upon an authorization given to us.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although your health record is the property of High Plains Oncology that created it, you have the right to:

- Request a restriction, in writing*, on certain uses or disclosures of your medical information for treatment, payment or health care operations, with the exception of emergency situations. We will consider your request, **but we are not legally required to agree to a requested restriction.** We will inform you of our decision on your request.
- Obtain a paper copy of this notice of our privacy practices upon request.
- Inspect and obtain a copy of your medical information, in most cases.
- Request in writing*, an amendment to your records if you believe the information in your record is incorrect or important information is missing. We could deny your request to amend a record if the information was not created by us, maintained by us, or if we determine the record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- Obtain an accounting of disclosures stating who and where your health information has been disclosed for purposes other than treatment, payment, health care operations or where you specifically authorized a use or disclosure in the past six (6) years, but not prior to April 14, 2003. The request must be in writing and state the time period desired for the accounting*. After the first request, there may be a charge.
- Request that medical information about you be communicated to you in a confidential way or at an alternative location but you must specify how or where you wish to be contacted.

*All written requests or appeals should be submitted to our Privacy Official listed at the bottom of this notice.

CHANGES TO THIS NOTICE

The center has the right to change this notice at any time. We have the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the center. The notice will contain the effective date. In addition, you may request a copy of the current notice each time you register for treatment or health care services.

COMPLAINTS

If you have questions or would like additional information, or if you believe your privacy rights have been violated, you can contact the High Plains Oncology Privacy Officer via mail or call 575/942-2550. You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights, 200 Independence Avenue, S. W., Washington, DC 20201. Filing a complaint will not negatively affect the treatment or coverage that you receive.

PRIVACY OFFICIAL

(575) 942-2550
5916 N. Lovington Hwy.
Hobbs, NM 88240

Notice of Privacy Practice

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**

Privacy Notice Acknowledgement

I have reviewed High Plains Oncology's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

Signature of Patient or Personal Representative

Date

Print Name