SIERRA HEMATOLOGY & ONCOLOGY

Medical Center, a Professional Corporation

REGISTRATION FORM

Last Name ___________________ First Name ________________________ MI________ DOB ____/ _____/ ______

Address Street ____ Apt/Space#: _________________

City, State, Zip ____

Gender: Sex ☐ Male ☐ Female

Gender Identity ☐ Male ☐ Female ☐ Female-to-Male (FTM)/ Transgender Male/ Trans Man ☐ Choose not to disclose
☐ Male-to-Female/ Transgender Female/Trans Woman ☐ Genderqueer; neither exclusively male nor female

Sexual Orientation ☐ Straight or Heterosexual ☐ Bisexual ☐ Choose not to disclose ☐ Don't Know
☐ Lesbian, Gay or Homosexual

Home Phone ____________________ Cell Phone____________________ Alt. Phone_________________________

Emergency Contact Name: ___________________________ Relation: _______________ Phone: _______________

Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Decline to state ☐

Ethnicity__________________ ☐ Decline to Specify Race __________________ ☐ Decline to Specify

Employer _______________________________ Phone: _________________ Occupation______________________

Primary Insurance Name ___________________________________ Group#: ________________________________

Primary Insurance Subscriber Name: ____________________________ ID#: ________________________________

Secondary Insurance Name _________________________________ Group#: ________________________________

Secondary Insurance Subscriber Name: __________________________ ID#: ________________________________

*****PLEASE HAVE YOUR INSURANCE CARD AVAILABLE TO BE COPIED AT EACH APPOINTMENT*****

Assignment and Release
I, the undersigned, have insurance coverage with ____and assign directly to Sierra Hematology & Oncology all Medical Benefits, if any, otherwise payable by me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to assume payment of benefits. I authorize the use on this signature on all my insurances submissions.

_______________________________________ ___________________________

Signature of insured/guardian **Date**

Medicare Authorization
I request that payment of authorized Medicare benefits be made on my behalf to Sierra Hematology & Oncology, or any of its individual providers, for any services furnished to me by any of its individual providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me or my legal representative in writing.

_______________________________________ ___________________________

Beneficiary Signature **Date**

Notice of Privacy Practices Patient Acknowledgement
By signing below, I acknowledge that I have reviewed the Notice of Privacy for Sierra Hematology & Oncology Medical Center, a Professional Corporation.

_______________________________________ ___________________________________ __________________________

Signature of Patient/Representative **Printed Name** **Relation to Patient**

Personal Information Release – Authorization for Listed Family and Friends to receive Medical Information
The below listed persons are hereby authorized to receive any and all information pertaining tom health and medical information:

____________________________________ ____________________________________ ____________________________________

____________________________________ ____________________________________ ____________________________________

____________________________________ ____________________________________ ____________________________________

Patient Signature: ___________________________________ **Printed Name:** ____________________________ **Today's Date:** _________________

SIERRA HEMATOLOGY & ONCOLOGY

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Patient Medical History Questionnaire

Full Name: ___________________________________ Date of Birth: ____/____/________ Today's Date: __________________

Primary Physician: ____ Phone Number: ___________________________________

Pharmacy Name & Address or nearest cross streets: ____

Allergies:

____

Smoker: Past ☐ Present ☐ Never ☐ Years smoked: _______ Daily number smoked: _________ Years since quit: ________

Alcohol: Past ☐ Present ☐ Never ☐

Recent Screenings & approximate date done:

Mammogram: _______________ Colonoscopy: ____________________ Sigmoidoscopy: _______________________
Dexa Scan: _________________ Pap Smear: ______________________ EGD (Upper Endoscopy): ________________
Pelvic Exam: _________________ Barium Enema: ___________________ Stool occult blood screening: _____________

Immunizations and Dates:

Flu vaccine: _________________ Pneumonia: ______________________ Chicken Pox: ___________________________
Tetanus: ____________________ DTaP: ___________________________ Mumps, measles, rubella: ________________
Other: ______________________

Family History of Cancer – Type, Relation to You, and if alive or deceased:

Family History of Heart Disease – Relation to you, and if alive or deceased:

Family History of Other Health issues – Relation to you, and if alive or deceased (Diabetes, COPD, Hypertension, Blood Disorders):

Surgeries/Biopsies – When and where:

Radiotherapy – When and where:

Emergency Room Visits – When and where:

Hospitalizations – When and where:

Transfusions – When and where:

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Physician List

Full Name: ______________________________________ Date of Birth: ___/___/______ Today's Date: ______________________

Primary Physician Name: ____ Phone Number: ________________________________

******Please complete the following for each physician you are currently seeing******

Name of Physician	Specialty	Phone Number

MEDICATION LIST

Name of Medication	Strength (mg)	Number at a time	Times per day	How Long
SAMPLE: Tylenol	500mg	2 tabs	3	2 weeks

Pharmacy name and address (or nearest cross streets if address not known):

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