NGOC NORTHWEST GEORGIA ONCOLOGY CENTERS

Wellstar HEALTH SYSTEM

JASPER LOCATION ONLY

Patient Registration Form

You have been scheduled with WellStar Medical Group Oncology. We know your time is valuable; to make your visit as efficient as possible, this Patient Registration Form is needed by your physician at the time of your visit.

Please complete these forms as accurately as possible and bring them with you to your appointment. Your physician will need a complete list of medications you are taking, any allergies you may have and other history which may have an impact on your healthcare. This information will assist your physician in obtaining a complete picture of your medical, surgical and social history.

Completion of this information before your scheduled appointment will make your visit more efficient and the information provided will help you and your physician make the best healthcare decision possible.

We ask that you bring your insurance/pharmacy cards and picture ID.

Thank you,
WellStar Health System Medical Group Oncology

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Patient Registration Form

PATIENT INFORMATION

Patient Last Name | Patient First Name | Date of Birth | Age | M F Gender

Street Address | City | State | Zip Code | Social Security Number

Home Telephone | Work Telephone | Mobile Number | Email Address | Choose One Marital Status

Check if primary. | Check if primary. | Check if primary.

Y N Interpreter? | Primary Language | Written Language | Choose One Ethnicity Hispanic or Latino? | Choose One Race | Religion

Y N Active MyChart | Employer Name | Full-Time Part-Time Unemployed Retired Disabled Student Employment Status

Employer Address | City | State | Zip Code | Telephone Number

Emergency Contact Last Name | First Name | Pharmacy Telephone Number

Emergency Contact Relation to Patient | Y N Legal Guardian? | Y N Hearing Impaired? | Y N Visually Impaired?

Primary Care Physician | Home Telephone | Work Telephone | Mobile Number

Check if primary. | Check if primary. | Check if primary.

RESPONSIBLE PARTY / GUARANTOR

CHECK IF SELF AND SKIP THIS SECTION

Guarantor Last Name | First Name | Guarantor Date of Birth | M F Gender

Guarantor Street Address | City | State | Zip Code | Social Security Number

Guarantor Employer Name | Full-Time Part-Time Unemployed Retired Disabled Student Employment Status | Guarantor Home Telephone | Guarantor Work Telephone

MEDICAL INSURANCE POLICY HOLDER

CHECK IF SELF AND SKIP THIS SECTION

Primary Insurance Company | Policy Holder Last Name | Policy Holder First Name

Relationship to Patient | Subscriber ID | Group Number | Social Security Number | Date of Birth

Secondary Insurance Company | Policy Holder Last Name | Policy Holder First Name

Relationship to Patient | Subscriber ID | Group Number | Social Security Number | Date of Birth

Patient Registration Form

ASSIGNMENT OF BENEFITS / CONSENT FOR TREATMENT

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize WellStar Medical Group to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to me taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

CONSENT TO CONTACT

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consume, Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care followup, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state, and specifically any claim under the CAN-SPAM Act. 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

☐ I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Signature of Patient / Legal Guardian

Date

Patient Registration Form

PATIENT COMMUNICATION DESIGNATION

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Last Name | Patient First Name | Date of Birth

Street Address | City | State | Zip Code | Social Security Number (optional)

Primary Contact Number | Medical Record Number

If we cannot reach you at the telephone number listed above, WellStar may contact you including leaving messages regarding appointments or normal lab results at the following number(s):

Home Telephone ☐ Check if primary.

Work Telephone ☐ Check if primary.

Mobile Number ☐ Check if primary.

I authorize WellStar Health System to disclose Protected Health Information to the following persons:

☐ **Spouse:** Name | Phone Number

☐ **Child(ren):** Name | Phone Number

Name | Phone Number

☐ **Other:** Name | Phone Number

Information to be disclosed:

☐ All medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.

Signature / Date: (date authorization signed by Patient or Legal Guardian / Personal Representative) | Date

Print Patient Name or Name of Legal Guardian / Personal Representative | Signature of Patient or Legal Guardian / Personal Representative

Indicate relationship to Patient (required)

Expiration Date:
This authorization is valid until written notice is provided to revoke this authorization.

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NEW PATIENT HEALTH HISTORY FORM

Patient Last Name | Patient First Name | Date of Birth | Today's Date

Referring Physician | Other Physicians you see: | Other Physicians you see:

Reason for visit:

		Diagnosis Year			Diagnosis Year
High Blood Pressure	Y N		Kidney Problem	Y N	
Bypass/Valve Replacement	Y N		Stomach Problem	Y N	
Pacemaker or Defibrillator	Y N		HIV	Y N	
Congestive Heart Failure	Y N		Hepatitis	Y N	
Heart Attack / Rhythm Problem	Y N		Osteoporosis	Y N	
Thyroid Problem	Y N		Seizures	Y N	
Diabetes	Y N		Blood Clots	Y N	
Asthma or COPD	Y N		Prior history of Cancer	Y N	
Gout	Y N		Depression	Y N	

Other illness not listed above:

Prior Surgeries:

		Year			Year			Year
Gallbladder	Y		Spleen	Y		Colon	Y	
Uterus	Y		Lumpectomy	Y		Joint Replacement	Y	
Ovaries (one)	Y		Mastectomy	Y		Prostate	Y	
Ovaries (both)	Y		Stomach Bypass	Y				

Health Maintenance: Fill in all that apply.

		Date			Date
Colonoscopy	Y		Prostate Exam	Y	
Mammogram	Y		Pap Smear	Y	

Gynecologic History: Fill in all that apply.

First menstrual period age? Age | Last menstrual period (menopause) age? Age | Number of pregnancies?

Birth control pills Y N | Hormone replacement therapy? Y N

continue >

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NEW PATIENT HEALTH HISTORY FORM

Patient Last Name | Patient First Name | Date of Birth

Social History:

Tobacco Use Y Please explain below N No and have never

		Packs per day / How often?	Years of use?			Packs per day / How ofen?	Years of use?
Cigarettes	Y N			Cigar	Y N		
Pipe	Y N			Chewing Tobacco	Y N		

Do you drink alcohol Y N

- Occasionally
- Daily
- Beer / Wine
- Hard Liquor

Choose One
Marital Status

Occupation:

Family History:	Alive	Age	List Illnesses or Cause of Death
Mother	Y N		
Father	Y N		
Siblings (brother/sister)	Y N		
Other	Y N		

Are you allergic to any medications? Y N

Please List:

Medications: List all medicines and supplements you take:

Medication	Start Date	Dose	How often?	Reason

continue >

Patient Registration Form

MEDICATION LOG

Use this form to keep a record of all prescribed medications. Talk to your provider or your pharmacist if you have any questions regarding your medications or if you're experiencing unexpected complications or side effects.

- If medication or treatment prescribed by your physician doesn't seem to help the problem, please let your provider know.
- Please check your medications at the beginning of each week to make sure you will have enough until your next visit.
- Please allow a 24 hour notice for prescription refills.
- Pain medications require a written prescription from your physician and cannot be refilled on weekends or after office hours.

PATIENT INFORMATION

Patient Last Name | Patient First Name | Date of Birth

Date form completed:

1

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

2

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

Patient Registration Form

MEDICATION LOG

3

Medication Name

Prescription Number

Date Prescribed

Prescribing Doctor

Dosage

Date Started

Date Ended

Reason Prescribed

Notes

Side Effects experience

4

Medication Name

Prescription Number

Date Prescribed

Prescribing Doctor

Dosage

Date Started

Date Ended

Reason Prescribed

Notes

Side Effects experience

5

Medication Name

Prescription Number

Date Prescribed

Prescribing Doctor

Dosage

Date Started

Date Ended

Reason Prescribed

Notes

Side Effects experience