# NEW PATIENT QUESTIONNAIRE

Patient Name: ______________________________________ Date: _________________

Welcome to the Pasadena CyberKnife Center! We hope the time you spend with us will be helpful, informative and healing. Please take the time to answer the following questions so that our physician will be able to evaluate your health concerns thoroughly.

****** On the day of your appointment,
please remember to bring your insurance card and a picture ID ******

Patient Name (last, first, middle): ________________________________________________

Address: ___________________________________________________________________
Street

___________________________________________________________________
City State Zip Code

Phone Number: (Home) __________________________ (Cell) _________________________

(Work) __________________________

Date of Birth: _______________________ Social Security #: ___________________________
MM/DD/YYYY

Email Address: _______________________________________________________________

Sex: M / F Retired? YES / NO If "Yes", date you retired? ____________________

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Race: American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Other Pacific Islander White

Marital Status: Single Married Divorced Widowed

**Patient Name:** ______________________________

Religion: ____________________________________________________________

Preferred Language: ___________________________________________________

Name of Emergency Contact: _____________________________________________

Phone Number of Emergency Contact: ______________________________________

Employer’s Name: _____________________________________________________

Employer’s Phone #: ___________________________________________________

Employer”s Address: ___________________________________________________
Street

_____________________________________________________
City State Zip Code

Health Insurance Provided by Employer: ____________________________________

Is this a Workers Comp case? Yes No

How did you find out about our center?

Referred by doctor Referred by insurance company Family & friends

Google Ad Search engine Facebook Yelp Internet

Other _________________________________________________________

***I authorize the release of medical information and emergency contact notification to:***

Name: _____________________Relationship: ______________Phone: ____________

Name: _____________________Relationship: ______________Phone: ____________

Patient Name: ___________________________________

## PHYSICIAN CONTACTS

| Name<br>Primary Care Physician | Address | Telephone | Fax Number |
|---|---|---|---|
| | | | |
| **Medical Oncologist** | **Address** | **Telephone** | **Fax Number** |
| | | | |
| **Surgeon** | **Address** | **Telephone** | **Fax Number** |
| | | | |
| **Other Physician** | **Address** | **Telephone** | **Fax Number** |
| | | | |

**SURGERY** – Check any major surgeries you have undergone, along with the approximate year they were performed.

| Check Below | Procedure | Year |
|---|---|---|
| | Appendectomy | |
| | Tonsillectomy | |
| | Cesarean Section Delivery | |
| | Hysterectomy | |
| | Other | |
| | Other | |
| | Other | |

**Family History:** Please list any of your blood relatives who have had cancer. Please note if they are living or deceased. If you know the kind of cancer (breast, prostate, colon, lung, etc), please list it also.

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**Patient Name:** ________________________________________

Do you have any of the following illnesses or medical problems?

| Illness or medical conditions | Yes | No |
|---|---|---|
| High Blood Pressure | | |
| Diabetes (High blood sugar) | | |
| Heart Disease (chest pain, heart attack) | | |
| Asthma or emphysema | | |
| Stomach ulcers or gastritis | | |
| Rheumatoid arthritis | | |
| Internal diverticulosis | | |
| Lupus or scleroderma | | |
| Autoimmune or connective tissue disease | | |
| Other: | | |

Please list any other major illnesses (requiring a hospital stay or regular visits to your

physician): ______________________________________________________________________

__________________________________________________________________________________

## MEDICATIONS

List all medications that you are presently taking:

| Name of the Medication | Amount You Take Daily |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## ALLERGIES

If you have any known allergies to medications, foods or other substances, please list them below and briefly explain your reaction. If no known allergies, please check the box below.

No Known Allergies

| Allergic To: | My Reaction: |
|---|---|
| | |
| | |
| | |

**Patient Name:** ________________________________________

Tell us about your teeth: Do you wear dentures? Yes No

How is your dental health? Excellent Good Poor

## HABITS

**Tobacco:** Do you smoke? Yes No

Number of cigarettes/cigars per day: ____________________________________

Number of year you have smoked: ______________________________________

If you have quit smoking, how along has it been? __________________________

Do you use “chew” or “snuff”? Yes No

If “Yes”, how long have you been using it? _________________________

**Alcohol:** Do you drink alcoholic beverages? Yes No

How many drinks per day? ____________________________________________

Do you ever drink heavily? (More than 2-3 drinks daily) Yes No

If “Yes”, how many years have you been drinking heavily? ____________

**Caffeine:** Do you drink coffee, tea or soda? Yes No

How many cups/cans do you drink per day? ______________________________

## FOR WOMEN ONLY

Are you currently pregnant? Yes No

Are you sexually active? Yes No

Number or pregnancies: _____________________ Number of children: ____________________

Age at first period: ________ Age at first pregnancy: ________ Age at last period: __________

Last Mammogram: _________________________ Last Pap smear: ______________________

Have you ever taken estrogen or other hormone replacement therapy? Yes No

If “Yes”, how many years have you been taking it? _______________________________

## FOR MEN ONLY

Last PSA/Labs: __________________________________________________________________

**Patient Name:** ________________________________________

## LIVING SITUATION AND SOCIAL FACTORS

Who lives with you? (Spouse/children/parents/etc.)

________________________________________________________________________________

Do you live in a nursing home? Yes No

If "Yes", which one? ________________________________________________________

What is your occupation? ________________________________________________________

Who provides assistance and emotional support for you during this illness?

(Please check all that apply) Spouse Family Friends Church Group

Therapist Cancer Support Group Social Worker

Neighbors Others ____________________________________

Patient Name: ______________________________________

## REVIEW OF SYMPTOMS

Check any of the following symptoms that you have experienced in the past few months:

| SYMPTOM | CHECK HERE | ONSET DATE | SYMPTOM | CHECK HERE | ONSET DATE |
|---|---|---|---|---|---|
| **CONSTITUTIONAL** | | | **GASTROINTESTIAL** | | |
| Appetite | | | Abdominal Pain | | |
| Fatigue | | | Constipation | | |
| Fever | | | Diarrhea | | |
| Lethargy (lack of energy) | | | Heartburn/Dyspepsia | | |
| Malaise (feeling of discomfort) | | | Hematemesis (vomit blood) | | |
| Night Sweats | | | Hematochezia (blood in /with stool) | | |
| Rigors/ Chills | | | Hemorrhoids | | |
| Weight Loss (more than 5 pounds) | | | Melena/GI bleeding | | |
| **EYES & ENT (Ears, Nose, Throat)** | | | Nausea | | |
| Dysphagia (difficult swallow) | | | Pain/Cramping | | |
| Ear Pain | | | Satiety | | |
| Epistaxis (nosebleed) | | | Vomiting | | |
| Esophagitis | | | **GENITIOURINARY** | | |
| Hearing Problems | | | Dysuria (painful urination) | | |
| Mouth Dryness | | | Urinary Frequency | | |
| Oral Bleeding | | | Genital Masses | | |
| Otitis (inflammation of middle ear) | | | Hematuria (blood in urine) | | |
| Sinusitis | | | Incontinence | | |
| Sputum Production | | | Nocturia (getting up at night to urinate) | | |
| Stomatitis | | | Renal Stone Disease | | |
| Taste Altered | | | Urgency | | |
| Tinnitus (ringing in ear) | | | Urine Color Change | | |
| Sore Throat | | | Vaginal Discharge/Bleeding | | |
| Double Vision | | | Vaginal Spotting | | |
| **CARDIOVASCULAR** | | | Retrograde Ejaculation | | |
| Arrhythmias (irregular heart rate) | | | Scrotal Swelling | | |
| Chest Pain | | | **NEUROLOGIC** | | |
| Dyspnea (difficult breathing) | | | Disorientation | | |
| Edema | | | Dizziness | | |
| Orthopnea( short of breath) | | | Gait | | |
| Palpitation | | | Headaches | | |
| **RESPIRATORY** | | | Insomnia | | |
| Cough | | | Memory Loss | | |
| Dyspnea | | | Neuropathy-motor | | |
| Hemoptysis | | | Paralysis | | |
| Hiccoughs (Hiccup) | | | Seizure | | |
| Chest Pain | | | Sensory problems | | |
| Wheezing | | | Stroke | | |

**We appreciate you taking the time to complete these questions.**
**This will assist us in providing you with excellent care. Thank you!**

## Financial Policy

The physicians at Pasadena CyberKnife Center are committed to providing you with the best possible medical care, and are pleased to discuss our professional fees and Financial Policy. Your clear understanding of our Financial Policy is important to our professional relationship.

- All Patients must complete our "Patient Information Form" before being seen by the doctor and this form must be updated at least once a year
- Cash patients will need to pay in full at the time of service
- The payment of any deductible or co-payment is due at the time of service
- The payment of the balance of any insurance charges that are more than 90 days from the date of service are also due immediately and at the time of any subsequent service
- We accept cash, check, or credit card
- A $25.00 fee will be charged for all returned checks

**ADULT PATIENTS**

Adult patients are ultimately responsible for payment for all medical services.

**MINORS ACCOMPANIED BY AN ADULT**

The parents or legal guardians of minors are ultimately responsible for payment for all medical services.

**REGARDING INSURANCE**

We will bill your insurance **as a courtesy to you,** and we will make every legal and ethical attempt to maximize your insurance benefits. But **you** must be responsible for any deductibles, co-payments, denied or non-covered services. We ***cannot*** accept your insurance payment as payment in full. If after **90 days** from the date of service we are unable to obtain payment from your insurance company then you will be responsible for payment in full.

Initials_____

Medical insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, non covered charges, secondary insurance etc., other than to supply factual information as necessary.

While we know you have to make many decisions regarding medical care, we hope that the quality of service our physicians are determined to provide will be worth the investment that you make in your health care.

If there are any changes made to your Health Coverage/Medical insurance during the course of your treatment, all unpaid claims will become your *total financial responsibility.*

Initials______

*I have read and understood all the above mentioned terms of this "Financial Policy".*

_________________________________ _________________________

Signature of Patient /Legal Guardian Date

_________________________________ _________________________

Responsible Party to Patient Date

# CONSENT FOR CYBERKNIFE RADIOSURGERY

**Patient Name:** ___________________________

**Date of Birth:** ___________________________

**Patient ID #:** ___________________________

**Patient Portal:** _______ **Accept**

_______ **Reject**

My physician has informed me that CyberKnife Radiosurgery has been recommended for the therapeutic treatment of my disease. The treatment is to be determined by the radiation oncologist (M.D.) and will be administered by the licensed radiation therapist (s) under his/her supervision.

The CyberKnife Radiosurgery will be administered Monday through Friday. There are no scheduled treatments on the weekends. The treatment modality is to be determined by the radiation oncologist. The Cyberknife radiosurgery may be interrupted as deemed advisable by the radiation oncologist and resumed at his/her discretion.

Diagnostic procedures, x-rays, CT scans, and/or MRI scans may be ordered to evaluate and monitor the therapeutic effect. Blood tests will be ordered to monitor the blood chemistry.

My physician has explained to me the most frequently occurring side effects. My condition will be monitored and I will be advised as to what to do for these side effects. Treatment may be interrupted should these conditions become severe and resumed when cleared or improved.

I understand that pregnancy should be avoided during the course of radiation therapy. The risks of reproductive harm to myself and harm to my unborn child have been discussed with me, if appropriate to my situation.

The physician has discussed with me the alternative methods of treating my disease, including the option of no treatment and the risks and benefits likely to be associated with such alternatives.

No guarantee or assurance has been given to me regarding the outcome of success of this treatment.

The physician has answered any questions that I may have concerning this treatment. I understand that my consent for this treatment is entirely voluntary and that I may withdraw my consent at any time that I change my mind and the radiation will be discontinued.

I have read and understand the above. The risks and benefits of this treatment have been explained to me and my physician has answered any questions that I have at this time. With my signature below, freely and voluntarily, I consent to this treatment.

I consent to the marking of my skin with ink or a tattooed “dot” for accurate localization of the radiation.

I consent to have photographs taken of my face for identification and of the site (s) of the treatment area for documentation. These photographs will become a permanent part of my medical record.

_________________________________________ _________________________

PATIENT SIGNATURE DATE

_________________________________________ _________________________

RESPONSIBLE PARTY TO PATEINT DATE

_________________________________________ _________________________

WITNESS/TRANSLATOR SIGNATURE DATE

_________________________________________ _________________________

PHYSICIAN SIGNATURE DATE

# CT/MRI SCAN QUESTIONARIE

Patient Name: ________________________________ Date of Birth: _____________

| | | |
|---|---|---|
| 1. Are you diabetic? | YES | NO |
| 2. Do you have any metal objects in your body? | YES | NO |
| 3. Do you have a pacemaker? | YES | NO |
| 4. Do you have kidney problems? | YES | NO |
| 5. Have you had an allergic reaction to IV contrast? | YES | NO |
| 6. Are you allergic to seafood? | YES | NO |
| 7. Are you claustrophobic? | YES | NO |
| 8. Do you have asthma? | YES | NO |

**** If you have asthma, please bring your inhaler the day of your CT exam ****

| | | |
|---|---|---|
| 9. Do you have any stents placed? | YES | NO |

If YES, when and where? ________________________________________

| | | |
|---|---|---|
| 10. Do you take **Metformin** or **Glucophage**? | YES | NO |

**** If you take **Meftormin** or **Gucophage**: Do **NOT** take your **Metformin** or **Glucophage** on the day of your CT scan and up to 48 hours after the exam ****

***** FOR PHYSICIAN USE ONLY *****

| | | |
|---|---|---|
| IV contrast contraindicated? | YES | NO |

Per review of form by:

Dr. Albert C. Mak Dr. Sara Kim Dr. Ana Grace Dr. Janice Rha

## PATIENT REGISTRATION FORM

**PATIENT NAME:** **DATE OF BIRTH:**

**ADDRESS:** **HOME PHONE:**

**CITY:** **SOCIAL SECURITY:**

**REFERRING PHYSICIAN:** **OFFICE PHONE:**

## INSURANCE INFORMATION

**PRIMARY INS:** **NAME OF INSURED:**

**POLICY#** **GROUP #**

**SECONDARY INS:** **NAME OF INSURED:**

***Assignment of Insurance Benefits:***

I hereby authorize payment directly to Pasadena CyberKnife Center and in the event of insurance to myself, I agree to authorize release of the Explanation of Insurance Benefits. In the event of any refusal of any insurance company or attorney to pay the bill, I agree to pay the balance. I agree to be responsible for said debt and any collection fees involved in the collection of this debt. I also understand that Pasadena CyberKnife Center bills/submits claims to my insurance for medical services rendered at the facility as a courtesy. However, in order to perform this courtesy, I the patient must provide Pasadena CyberKnife Center with all the necessary information/documentation pertaining to my insurance/medical coverage to do so.

**PATIENT/GUARANTOR SIGNATURE**: ___________________________________ **DATE:**________________________

***Release of Information*:**

This authorization or photo copy hereof, will authorize the release of full and complete medical records/reports and any other records when necessary to governmental agencies, insurance carriers, and review agencies for payers responsible for pre-certification and payment services rendered. I also authorize the center to permit such payers and their review agencies to examine and make copies of my records as requested for payment as permitted by Federal and State law. I further authorize release of previous medical records as requested by the center.

**PATIENT/GUARANTOR SIGNATURE**: ___________________________________ **DATE:**________________________

***Authorization for Release of Medical Information*:**

I hereby authorize the release of my records from:

______________________________________________________________________________________________ to

(Facility Name/Address)

**Pasadena CyberKnife Center at 630 S. Raymond Ave, Suite 104, Pasadena, CA 91105**

**Notice of Privacy Practices Acknowledgement Form**

I understand that as part of my healthcare, this organization creates and maintains health records describing my healthy history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer (e.g. insurance carrier) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and outcomes

*I have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.*

__________________________________ ____________________
Patient Signature Date

__________________________________
Print Name

__________________________________ ____________________
Translator’s Signature Date

__________________________________
Print Name