KSK MEDICAL GROUP

Cancer Center of Irvine
16100 Sand Canyon Ave, Ste 130
Irvine, CA 92618
P: 949.417.1100 F: 949.417.1165
www.kskcancercenter.com

PATIENT REGISTRATION

DATE: _____

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)			ADDRESS	
CITY		STATE/ ZIP	BEST CONTACT # (SPECIFY CELL, HOME, WORK)	ALTERNATIVE #
DOB	AGE	SEX □ MALE □ FEMALE	MARITAL STATUS □ MARRIED TO _____ □ SINGLE □ OTHER _____	SOCIAL SECURITY #
EMAIL				OCCUPATION
ETHNICITY □ HISPANIC /LATINO □ NOT HISPANIC/LATINO □ UNKNOWN □ DECLINE TO STATE			PREFERRED LANGUAGE:	RACE: □ DECLINE TO STATE
INSURED/RESPONSIBLE PARTY INFO	RELATION TO PATIENT: □ SELF □ SPOUSE □ OTHER_____ *IF INSURED/RESPONSIBLE PARTY IS SELF SKIP TO INSURANCE INFORMATION			
RESPONSIBLE PARTY NAME (FIRST, MIDDLE INITIAL, LAST)			RESPONSIBLE PARTY DOB	RESPONSIBLE PARTY SOCIAL SECURITY #
INSURANCE INFORMATION				
PRIMARY INSURANCE CARRIER	MEMBER ID #		GROUP #	
SECONDARY INSURANCE CARRIER	MEMBER ID #		GROUP #	
EMERGENCY CONTACTS				
NAME (FIRST, LAST)			RELATIONSHIP TO PATIENT	PHONE #
ADDRESS			CITY	STATE/ZIP
NAME (FIRST, LAST)			RELATIONSHIP TO PATIENT	PHONE #
ADDRESS			CITY	STATE/ZIP
COMMUNICATIONS (PLEASE CHECK HOW YOU WOULD LIKE TO RECEIVE THE FOLLOWING)				
CLINCIAL SUMMARY/SUMMARY OF CARE	□ PRINT COPY □ EMAIL			
PATIENT INFORMATION/REMINDERS	□ PRINT COPY □ EMAIL			

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PHYSICIAN'S LIST

Please list all doctors that you see, so we can inform them on your progress

- Referring doctor: _____
  - Phone #: _____ Fax #: _____
- Primary Care Physician: _____
  - Phone #: _____ Fax #: _____
- Oncologist: _____
  - Phone #: _____ Fax #: _____
- Other Physician: _____Specialty: _____
  - Phone #: _____ Fax #: _____
- Other Physician: _____Specialty: _____
  - Phone #: _____ Fax #: _____
- Other Physician: _____Specialty: _____
  - Phone #: _____ Fax #: _____
- Other Physician: _____Specialty: _____
  - Phone #: _____ Fax #: _____

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RELEASE TO PAY BENEFITS & FINANCIAL RESPONSIBILITY

PATIENT NAME: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION & PAYMENT

I hereby authorize KSK Cancer Center of Irvine (Kenneth M. Tokita MD Inc.) to release any medical information required during the course of examination and treatment to my insurance company(s). I also permit payment(s) to KSK Cancer Center of Irvine from my insurance for any benefits due for their services rendered.

Patient Initials: _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all charges incurred, regardless of insurance status. I agree to pay for all services and treatments incurred to KSK Cancer Center of Irvine (Kenneth M. Tokita MD Inc.). I also accept responsibility to provide accurate and current insurance. Failure to do so may result in charges billed directly to myself.

Patient Initials: _____

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT: MEDICARE

I understand and agree to the following:

- KSK Cancer Center of Irvine (Kenneth M Tokita MD Inc.) will be billing Medicare for medical services provided.
- KSK Cancer Center of Irvine (Kenneth M Tokita MD Inc.) is a Medicare provider and will accept Medicare assignment of benefits. Medicare generally pays 80% of the allowable charge after the yearly deductible is met, and the patient is responsible for the remaining 20% balance.
- If supplemental insurance information is provided, the claim will be sent to the secondary insurance before the patient is billed.

Patient Initials: _____

RELEASE TO PAY BENEFITS TO PHYSICIAN: PRIVATE INSURANCE

I understand and agree to the following:

- KSK Cancer Center of Irvine (Kenneth M Tokita MD Inc.) will be billing my insurance or myself for the medical services provided.
- If the insurance company does send the check(s) to me directly, I agree to send the checks to KSK Cancer Center of Irvine (Kenneth M Tokita MD Inc.) within 7 days of receipt of the checks from the insurance company.

Patient Initials: _____

_____ _____

Signature or Insured or Authorized Person Date

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AUTHORIZATION & REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

I hereby authorize and request my medical records to be released to Kenneth M. Tokita, M.D., Radiation Oncologist.

Authorized Recipient: _____

Please fax records to (949) 417-1165, or mail to: KSK Cancer Center of Irvine, 16100 Sand Canyon Ave Suite 130 Irvine, CA 92618.

Records to be released:

_____

_____

_____

I understand that I have a right to receive a copy of this authorization upon my request

_____ _____

Signature of Patient or Authorized Person Date

_____

Relationship if signed other than patient

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HEALTH QUESTIONNAIRE & MEDICATIONS

PATIENT NAME:	DOB:	AGE:	HEIGHT/WEIGHT:	OCCUPATION:

ALLERGIES: (Name AND Reaction)

MEDICAL HISTORY: ex: diabetes, cancer, hypertension

SURGICAL HISTORY:

	SURGERY YEAR	TYPE OF SURGERY

HAVE YOU BEEN DIAGNOSED WITH LUPUS, RHEUMATOID ARTHRITIS, COLLAGEN VASCULAR DISEASE, OR ULCERATIVE COLITIS?

NO YES (list which of the following): _____
DO YOU TAKE STEROIDS SUCH AS PREDNISONE? YES NO

FAMILY HISTORY: INDICATE ANY MEDICAL ISSUES WITHIN YOUR IMMEDIATE FAMILY. (if deceased, specify cause + age of death)

MOTHER:

FATHER:

SISTER:

BROTHER:

OTHER:

REVIEW OF SYSTEMS: CIRCLE APPLICABLE

GENERAL: HAVE YOU HAD 10+ POUNDS OF WEIGHT CHANGE WITHIN PAST 6 MONTHS? NO ISSUES -or- YES (explain): _____

SKIN: NO ISSUES -or- JAUNDICE, HIVES/RASHES, ECZEMA
Other: _____

HEAD: NO ISSUES -or- SERIOUS HEAD INJURIES
Other: _____

EYES: NO ISSUES -or- DOUBLE VISION, GLAUCOMA
Other: _____

EARS/NOSE/THROAT: NO ISSUES -or- FREQUENT NOSEBLEEDS, IMPAIRED HEARING, DIZZINESS, EPISODES OF UNCONCIOUSNESS, THROAT ISSUES
Other: _____

RESPIRATORY: NO ISSUES -or- SLEEP APNEA, ASTHMA, CHRONIC COUGH, WHEEZING, SHORTNESS OF BREATH
Do you sleep with a breathing machine? YES/NO

NECK/THYROID: NO ISSUES -or- THYROID ILLNESS, ENLARGED GLANDS
Other: _____

REVIEW OF SYSTEMS CONTINUED: CIRCLE APPLICABLE

CARDIVASCULAR: NO ISSUES -or- CHEST PAIN, HEART ATTACK, SHORTNESS OF BREATH, STENT PLACEMENT, A-FIB, HYPERTENSION, SWELLING OF HANDS/FEET/ANKLES
Other: _____

GI: NO ISSUES -or- HEPITITIS A/B/C, LIVER TROUBLE, HEART BURN/INDIGESTION, TROUBLE SWALLOWING
DATE OF LAST COLONOSCOPY: _____
Other: _____

MUSCULOSKELETAL: NO ISSUES -or- RHEUMATOID ARTHRITIS, OSTEO ARTHRITIS, MUSCLE-JOINT WEAKNESS OR DISEASE
Other: _____

NEUROLOGICAL: NO ISSUES -or- FAINTING SPELLS, CONVULSIONS, PARALYSIS, STROKES, HEAD INJURIES, SEIZURES
Other: _____

HEMATOLOGICAL: NO ISSUES -or- EASY BRUISING, ANEMIA, SLOWLY HEALING, BLOOD CLOTS, BLOOD DISEASE
Other: _____

ENDOCRINE: NO ISSUES -or- HORMONAL OR ENDOCRINE PROBLEMS, DIABETIC
Other: _____

PSYCHIATRIC: NO ISSUES -or- PSYCHIATRIC HISTORY: _____

URINARY/RENAL: NO ISSUES -or- KIDNEY DISEASE, BLADDER ISSUES, PROSTATE ISSUES
Other: _____

GYNECOLOGICAL: NO ISSUES -or- GYNECOLOGIAL ISSUES, CURRENTLY PREGNANT, POST MENOPAUSE,
FIRST DAY OF LAST MENSTRUAL PERIOD: _____
OF PREGNANCIES: _____
TYPE of CONTRACEPTIVE USE: _____

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PATIENT NAME

SOCIAL HISTORY

MARITAL STATUS: _____ SPOUSE NAME: _____

SMOKING: NO/YES
FREQUENCY: _____ # OF YEARS: ___ YEARS SINCE QUITTING: _____

ALCOHOL CONSUMPTION: NO/YES
FREQUENCY: _____ # OF YEARS: ___ YEARS SINCE QUITTING: _____

PREVIOUS RADITATION THERAPY: (please indicate the site treated, name of center, date)
_____

_____

EXERCISE TOLERANCE

CHECK the one that applies to you:

- **1-4 METs:** Standard light home activities, walk around the house, walk 1-2 blocks on level ground at 1-3mph
- **5-9 METs:** Climb a flight of stairs, walk up a hill, walk on level ground at ≥ 3mph
- **≥ 10 METs:** Strenuous sports (swimming, tennis, bicycle), or heavy professional work

METs: metabolic equivalents of Oxygen consumption

MEDICATION LIST

Medication/ Strength	How often	Purpose of Medication	Staff only- R=Resume S=Stop

Pharmacy & Pharmacy Phone Number: _____

Physician's signature: _____ Date: _____

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DISCLOSURE TO FAMILIES & LOVED ONES (HIPAA RELEASE FORM)

I authorize KSK Cancer Center of Irvine (Kenneth M. Tokita MD Inc.), to disclose my health information and to discuss my healthcare needs to those I designate. Without authorization, no information may be shared to others. Please disclose to the following people:

- _____ _____
  name (first, last) relationship
- _____ _____
  name (first, last) relationship
- _____ _____
  name (first, last) relationship

□ I do not authorize my healthcare information to be released to anyone

Patient Initials: _____

NOTICE OF PRIVACY PRACTICES

I certify that I have been made aware of KSK Cancer Center of Irvine's Notice of Privacy Practices and that I have a right to receive a copy upon request. This notice describes the type of uses and disclosures of my protected health information that may occur during my treatment, in addition to facilitate the payment of my bills. The notice also describes my rights and KSK Cancer Center of Irvine's duties with respect to my protected health information.

KSK Cancer Center of Irvine (Kenneth M. Tokita MD Inc.) reserves the rights to change the Notice of Privacy Practices. If changed, I may obtain a revised copy by contacting the office.

I acknowledge the receipt of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Person Date

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www.kskprocedurecenter.com

COMMON OFFICE POLICIES

Our goal at KSK is to provide you with excellent patient care. In order to do so, we ask that you abide by the following guidelines.

- Be on time for your appointments
- Be courteous to other patients and staff
- Do not speak on your cell phone in the waiting room
- Be an active participant in your treatment plan
- Understand that there is a “zero tolerance” rule against any form of verbal or physical abuse of staff
- Understand that there is a “zero tolerance” rule against any sexual advances towards our staff
- Communicate daily with therapists regarding symptoms and side effects
- Provide updated information in a timely manner (including but not limited to address, phone number, insurance information)
- Any cancellation made less than 24 hours prior to appointment time may incur a cancellation fee of $50
- We are happy to reschedule an appointment up to two times, after that it will be at the physician’s discretion to further schedule you

I understand and agree to the above policies:

_____ _____

Print Name Date

_____

Signature