Department of Radiation Oncology

Kenneth Rosenzweig, M.D., Chairman
Sheryl Green, M.D., Associate Professor
Vishal Gupta, M.D., Assistant Professor
Seth Blacksburg, M.D., M.B.A., Assistant Professor
Richard Bakst, M.D., Assistant Professor
Yeh-Chi Lo, Ph.D.
Barry Rosenstein, Ph.D.

The Mount Sinai Hospital
One Gustave L. Levy Place, Box 1236
New York, NY 10029-6574

REGISTRATION FORM

DATE: _____

PATIENT NAME: _____ SS# _____

BIRTHDATE: _____ AGE: BIRTHPLACE: _____

RACE: _____ RELIGION: _____

MARTIAL STATUS: _____ (please select Married, Single, Divorced, Separated, Widowed)

ADDRESS: _____

_____

HOME PHONE # _____ CELL # _____ WORK # _____

OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

_____

REFERRING PHYSICIAN: _____

PHONE # _____ ADDRESS _____

PRIMARY CARE PHYSICIAN: _____

PHONE # _____ ADDRESS _____

EMERGENCY CONTACT: _____

(please select one: RELATIVE, SPOUSE/FRIEND) _____

ADDRESS: _____

_____

HOME PHONE # _____ CELL # _____ WORK # _____

NAME OF INSURED & POLICY # _____

BIRTHDATE: _____ SS# _____ EMPLOYER _____

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Doctors

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SIGNATURE FORM

Release of Information

I authorize and direct Mount Sinai Hospital and any of the below-named physicians of The Radiation Oncology Associates of Mount Sinai School of Medicine, who have provided care to me, to release to governmental agencies, such as: Medicare and Medicaid, as well as any HMO, Insurance Carrier, or any other fiscal intermediary, who may be liable for my hospitalization and medical care, all information needed to substantiate payment for such services as are provided.

Assignment of Benefits

I authorize payment directly to Mount Sinai Hospital and any of the below-named physicians of The Radiation Oncology Associates of Mount Sinai School of Medicine, who have provided care to me. If my fiscal intermediary should pay me rather man the physician or hospital directly, I will sign over check to said provider, along with the explanation of benefits that accompanies the reimbursement check.

For Patients Entitled to Medicare

I certify that the information provided by me to Mount Sinai Hospital and any of the below named physicians of The Radiation Oncology Associates of Mount Sinai School of Medicine is correct to the best of my knowledge. Additionally, I authorize the release of Medical Information, as well as assignment of benefits, directly to the provider. I further acknowledge that I will be responsible for my annual Medicare deductible and co-payments for all Medicare-approved charges, according to the Medicare Fee Schedule in effect at the time of service. I understand that this is my responsibility to pay and that the hospital and physicians are required by Medicare to bill me for these charges.

_____ _____

Signature of Patient **Date**
Or Guardian (if minor)

If Patient is unable to sign: _____ _____

Witness **Date**

The Radiation Oncology Associates of Mount Sinai
- Dr. Richard Bakst
- Dr. Seth Blacksburg
- Dr. Sheryl Green
- Dr. Vishal Gupta
- Dr. Kenneth Rosenzweig

INSURANCE INFORMATION

Primary #1
Name of Insurance Carrier: _____

Policy Holder:	Relationship to Policy Holder (choose Spouse, Self, Other)	
Name:		
Date of Birth:		
Social Security Number:		
Policy Number:		
Group Number:		
	Is a Referral Form Required? Yes/No:	
	(if yes, be sure to attach to this form)	

Secondary #2
Name of Insurance Carrier: _____

Policy Holder:	Relationship to Policy Holder (choose Spouse, Self, Other)	
Name:		
Date of Birth:		
Social Security Number:		
Policy Number:		
Group Number:		

Tertiary #3
Name of Insurance Carrier: _____

Policy Holder:	Relationship to Policy Holder (choose Spouse, Self, Other)	
Name:		
Date of Birth:		
Social Security Number:		
Policy Number:		
Group Number:		

GUARANTEE OF ACCOUNT

The undersigned guarantees payment of all charges incurred, including balances remaining after insurance such as: deductibles and co-payments not covered by insurance.
The undersigned understands that Mount Sinai Hospital relies on this guarantee in rendering technical services to the patient and that the patient will be receiving a separate bill from the hospital for those services.
The undersigned further understands that the physicians of The Radiation Oncology Associates of Mount Sinai also rely on this guarantee in rendering professional services to the patient, and that the patient will receive a separate bill from the physician's office for those services.

_____ _____
Date Patient's Signature

_____ _____
Date Guarantor's Signature (if other than patient)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information

Signature of Patient or Personal Representative	
Print Name of Patient or Personal Representative	
Date	
Description of Personal Representative's Authority	

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- ☐ *The patient refused to sign despite good faith efforts*
- ☐ *The patient was unaccompanied and not alert and oriented*
- ☐ *The patient was unaccompanied and needed emergency care*
- ☐ *Other (explain)* _____

Employee Signature: _____ Employee Title: _____
Print Name: _____ Date: _____

☐ Acknowledgement subsequently obtained, (see above).

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Agreement to Receive Messages Containing PHI at Home

Name: _____
MRN: _____

I hereby authorize Dr. Bakst_____ or his/her designee to leave a message containing PHI necessary for my care

☐ On my answering machine at home or with anyone who answers my phone.
☐ At the following telephone number only: _____

Signature Patient: X_____

Signature Personal Representative:_____

PRINT NAME:_____

Authority:_____

Date:_____

MOUNT SINAI USE OF INFORMATION AUTHORIZATION

Dear Patient,

Like other major academic medical centers, Mount Sinai depends greatly upon the generosity of our patients to help us provide the finest in patient care, educate the next generation of physicians, and promote research and discovery of new treatments and cures.

Federal law now requires health care providers to obtain your written authorization prior to contacting you with marketing information or about philanthropic initiatives that support the work of your doctors. Your permission for disclosure of your name will allow Mount Sinai staff to contact you about marketing or philanthropic efforts that may be of interest to you.

No other information about you or your medical treatment will be disclosed- that is strictly between you and your doctor. Maintaining patient confidentiality and ensuring your right to privacy has always been, and will always be, a priority at Mount Sinai.

We hope you will take a moment to read this authorization and sign below. If you have any questions, please call the Mount Sinai Development Office at (212) 659-8500.

Thank you.

I authorize any doctor employed by or on the staff of The Mount Sinai Hospital and Mount Sinai School of Medicine ("Mount Sinai") to disclose my name and contact information to Mount Sinai development and public affairs staff for the purpose of contacting me about Mount Sinai marketing and philanthropy opportunities. I understand that my health care treatment at Mount Sinai will not be affected in any way by my refusal or failure to sign this form. I further understand that this authorized information will not be released to any third parties for any purpose other than that expressed above. This authorization will remain in effect for five years. However, I may revoke this authorization at any time by writing to the Mount Sinai Development Office, One Gustave L. Levy Place, Box 1049, New York, New York 10029-6574. By signing below, I acknowledge that I have read and accept all of the above.

X_____	X_____	X_____
Signature of patient or personal Representative/Guardian	***Print Name** of Patient or personal Representative/Guardian*	*Date*

X_____

Address of Patient

_____

If Applicable, Description of Authority of Personal Representative/Guardian

A signed copy of this form is available upon request by patient or patient representative

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INTAKE FORM

Today's Date: _____
Your Name (Last, First): _____

Preferred pharmacy

Name _____
Pharmacy address _____
Pharmacy phone number _____
Pharmacy fax number _____

Chief complaint (in your own words):

_____
_____

Past Medical Problems

Problem	Check if Yes	Explanation
Hypertension	☐	
High Cholesterol/Lipids	☐	
Diabetes	☐	
Heart Attack	☐	
Stroke	☐	
Lung Problems (COPD/emphysema)	☐	
(other)	☐	

Past surgeries and date(s)

1. _____
2. _____
3. _____
4. _____
5. _____

Prior chemotherapy?
Chemo name: _____
Regimen/dose: _____
Oncologist/oncology facility: _____

Prior chemotherapy?
Chemo name: _____
Regimen/dose: _____
Oncologist/oncology facility: _____

Prior chemotherapy?
Chemo name: _____
Regimen/dose: _____
Oncologist/oncology facility: _____

Prior Radiation?
When: _____
Dose: _____
Radiation Oncologist/oncology facility: _____

ALLERGIES to medications:

Name	reaction

FAMILY HISTORY of cancer?

_____
_____
_____

Medication list:

Name	Dose/frequency

Smoking history: _____

Packs per day _____

#years _____

Quit (if so, when)/active _____

Alcoholic beverages: _____

Review of systems: In the past few months, have you experienced any of the following: (all yes/no):

	Problem	Check if Yes	Explanation
Constitutional	Fatigue	☐	
	Fever	☐	
	Chills	☐	
	Weight Loss	☐	
	Other	☐	
Eyes/ears/nose/throat	Change in vision	☐	
	Painful swallowing	☐	
	Vertigo	☐	
	Nasal stuffiness	☐	
	Other	☐	

	Problem	Check if Yes	Explanation
Cardiac	Chest Pain	☐	
	Palpitations	☐	
	Dizziness	☐	
	Other	☐	
Respiratory	Shortness of breath	☐	
	Coughing	☐	
	Wheezing	☐	
	Other	☐	
Gastrointestinal	Change in stools	☐	
	Abdominal pain	☐	
	Constipation	☐	
	Other	☐	
Genito-urinary	Painful urination	☐	
	Bloody urination	☐	
	Other	☐	
Musculoskeletal	Joint pain	☐	
	Muscle spasm	☐	
	Swelling	☐	
	Other	☐	
Vascular	Leg cramps	☐	
	Tissue loss	☐	
	DVT	☐	
	Other	☐	
Neurologic	Headaches	☐	
	Dizziness	☐	
	Numbness	☐	
	Memory loss	☐	
	Other	☐	
Psychiatric	Anxiety	☐	
	Change in sleep pattern	☐	
	Depression	☐	
	Other	☐	

Gyn-specific questions *(only fill out if apply)*

Age of first menstruation: _____
Last menstrual period: _____
Have You ever been pregnant? YES/NO
Is there a chance you are currently pregnant? YES/NO
Number of pregnancies: _____
Number of children: _____
Age at first delivery: _____
Breastfeed? YES/NO
Hormone replacement therapy? YES/NO
If so, for how long?
Oral contraceptives? YES/NO
If so, for how long?
Infertility treatments? YES/NO
If so, when was the last one? _____

Breast-specific questions *(only fill out if apply)*

Have you had prior FNAs? YES/NO
Outcome(s)? _____
Have you had prior lumpectomies?
Outcome(s)? _____
Have you ever been personally tested for BRCA1/2? _____
Family tested for BRCA1/2? _____
Bra size? _____
Reconstructive procedures? _____

Head and neck-specific questions

Chewing tobacco/snuff/Betel or areca nut? _____
Which?
How many years? _____

Prostate-specific questions

Have you ever had treatment for BPH (benign prostatic hypertrophy)? YES/NO
If so, what medications did you take? _____

What is your PSA history?

_____

_____

Have you had prior prostate biopsies? YES/NO

If so, what were the results? _____