Solano Hematology Oncology, Inc.
100 Hospital Drive, Suite 110
Vallejo, CA 94589
Phone (707) 551-3300
Fax (707) 551-3301

Cancer Treatment Center of Vacaville
1360 Burton Drive, Suite 170
Vacaville, CA 95687
Phone (707) 446-1114
Fax (707) 446-1119

Chainarong Limvarapuss, M.D.
Walailuk Chaiyarat, M.D.
Ann M. Wexler, M.D.

PATIENT REGISTRATION AND INFORMATION

Patient Name_____**Today's Date**_____

Address_____**City**_____**State**_____**Zip**_____

Phone Number: Home_____ Work_____ Mobile_____

Social Security_____/____/_____ **Date of Birth**_____/_____/_____ **Gender:** ☐ Male ☐ Female

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____
Preferred method of contact: ☐Home Phone ☐Work Phone ☐Mobile ☐Email_____
May we leave voice mail and messages on your phone? ☐Yes ☐No
Race: ☐Caucasian ☐African American ☐Hispanic ☐Asian ☐Pacific Islander ☐Native American ☐Other_____
Preferred Language: ☐English ☐Spanish ☐Tagalog ☐Thai ☐Japanese ☐Other_____
Are you currently employed? ☐Full-time ☐Part-time ☐Unemployed ☐Retired

Spouse/Significant Other_____**Phone**_____

Emergency Contact_____**Phone**_____**Relationship**_____

Who is your primary care doctor?_____

Which doctor referred you to our practice?_____

Do you have an Advanced Directive? ☐ Yes ☐ No **If yes**, please provide a copy for our care records.
If no, would you like us to provide you with more information: ☐ Yes ☐ No

Primary Insurance Carrier_____**ID#**_____

Group#_____Policy#_____

Guarantor_____Relationship_____

Secondary Insurance Carrier_____**ID#**_____

Group#_____Policy#_____

Guarantor_____Relationship_____

<PLEASE PROVIDE YOUR INSURANCE CARDS AND A PHOTO ID FOR US TO COPY>

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

MEDICAL HISTORY QUESTIONNAIRE

Please check if you have had any of these medical conditions or problems. This information will help us to provide you with the best possible treatment. If you answer YES to any, please describe below.

	Yes	No		Yes	No
Anemia	☐	☐	Frequent Headache	☐	☐
Abdominal Swelling/Pain	☐	☐	Gall Bladder Problem	☐	☐
Arthritis (Where?)	☐	☐	Heart Condition (Type?)	☐	☐
Asthma/Bronchitis	☐	☐	Heartburn ARD	☐	☐
Bladder Infection	☐	☐	Hepatitis _____ (Type?)	☐	☐
Bleeding Disorder or Easily	☐	☐	High Blood Pressure	☐	☐
Blood Clots (phlebitis)	☐	☐	Hyperthyroidism	☐	☐
Blood in Stool/Urine	☐	☐	Hypothyroidism	☐	☐
Chest Pain	☐	☐	Kidney Problems (Type?)	☐	☐
Chronic Cough	☐	☐	Leg Pain / Swelling	☐	☐
COPD	☐	☐	HIV/AIDS	☐	☐
Constipation/Diarrhea	☐	☐	Back Pain	☐	☐
Convulsion/Seizure	☐	☐	Nausea / Vomiting	☐	☐
Depression/Anxiety	☐	☐	Osteoporosis	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Dizziness Fainting Spells	☐	☐	Tuberculosis	☐	☐
Emphysema / Pneumonia	☐	☐	Ulcers	☐	☐
History of Falling	☐	☐	Other condition or pain	☐	☐

If you answered YES to any above, please provide details. Please also list any other conditions not mentioned above:

_____

_____

_____

_____

Do you have any known **Allergies to Medications or Foods** ☐ Yes ☐ No

If yes, please list the medication/food:

_____

_____

_____

_____

Do you drink alcohol? (even occasionally) ☐ Yes ☐ No How often? _____Drinks per Week

Do you smoke? ☐ Yes ☐ No If yes, how often?_____ Packs per Week

Did you quit smoking? ☐ Yes ☐ No Since when?_____

How would you rate your overall health and physical condition?

☐ Excellent ☐ Above Average ☐ Average ☐ Below average ☐ Poor

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

TREATMENT AND FINANCIAL RESPONSIBILITY INFORMATION

Appointments: When you arrive, please stop at the front desk and let the office staff know you are here before being seated. In order to serve all patients promptly, please schedule all appointments in advance. This includes infusion and injection appointments

Cancellation Policy: Please understand that it is important to us to be available for all our patients and appointment times are precious. Please notify us 24-hours in advance if you need to cancel or change appointments. This allows us to accommodate patients who need to be seen urgently. We reserve the right to charge up to $50.00 appointment cancellation fee if we are not notified in advance that you cannot make your appointment.

Patient with Insurance: Although we will bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your insurance company/medical group, we will contact you for assistance. Should your insurance company/medical group deny coverage for any reason, you will be responsible for payment in full within thirty (30) days of your billing statement.

Dual Coverage: We abide by the California State insurance laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary, and tertiary insurance plans.

Co-Pay Policy: If your insurance has a co-pay, they require that you pay the co-pay at the time of the visit. A co-pay is collected for all office visits, including visits with the doctor or other medical staff, unless we indicate otherwise. Also included are office visits when chemotherapy is scheduled (even if the treatment is held due to medical condition) and visits for infections. This is regardless of whether the patient sees the doctor or not, since the doctor is involved with medical decision-making. If you anticipate any financial difficulty with paying your co-pay, please contact our billing staff as soon as possible.

Authorization & Assignment of Benefits: Please refer to our Notice of Privacy Practices. This authorizes us to release medical information to your insurance plan/medical group that may be needed to process/pay your claims. The "assignment of benefits" requests that insurance payments be made directly to us, and also acknowledges that you are responsible for payment if this assignment is not honored.

Patients without Insurance: Our fees cannot always be determined in advance, since they depend on the services rendered. You will be quoted a deposit amount, which must be paid at the time of service. Any charge over the deposit amount will be billed to you and will be due in full within thirty (30) days from the date of your billing statement. Please make payment arrangements in advance with our billing staff for costly services.

Miscellaneous Fees: Our fee for copying medical records is $25.00 and may take up to seven (7) business days. For completion of forms, such as disability forms, family leave applications, and DMV forms, as well as excuses from work letters and other letters, there will be a nominal fee of $5.00 to $15.00 depending upon the item being completed.

Returned Check: There is a $25.00 service fee for all returned checks.

I have read and understand the above policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

_____ _____

(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative) (Date)

_____ _____

(Printed Name) (Relationship to Patient)

Solano Hematology Oncology, Inc.
100 Hospital Drive, Suite 110
Vallejo, CA 94589
Phone (707) 551-3300
Fax (707) 551-3301

Cancer Treatment Center of Vacaville
1360 Burton Drive, Suite 170
Vacaville, CA 95687
Phone (707) 446-1114
Fax (707) 446-1119

Chainarong Limvarapuss, M.D.
Walailuk Chaiyarat, M.D.
Ann M. Wexler, M.D.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ D.O.B.: _____

Physician or Medical Facility To Release Information:

Name: _____ Phone: _____

Address: _____ Fax: _____

I hereby authorize the above named physician or medical facility to release my complete personal health information (medical records including diagnosis, physician notes, diagnostics, films, and other information) for purposes as needed, and as allowed by law, in the treatment and/or further diagnosis of my condition or illness.

I authorize this information to be released in its entirety to:

_____ Solano Hematology Oncology and Cancer Treatment Center of Vacaville
(Initial)
c/o Medical Records Dept.
100 Hospital Dr., Ste. 110, Vallejo, CA 94589
Phone: (707) 551-3300
Fax: (707) 551-3301

and/or

_____ _____
(Initial) (Name and Address of Physician, Medical Facility, or Other Individual or Group)

This authorization is to remain in effect indefinitely, as allowed by law. I also realize that I may revoke and terminate this authorization, for any future release or disclosures of my personal health information at any time, by submitting written notice of revocation to the previously authorized individual or entities authorized.

_____ _____
(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative) (Date)

_____ _____
(Printed Name) (Relationship to Patient)

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

Patient Profile, Information and Rx Disclosure

To better meet our patients' needs we can now dispense many of the prescriptions as prescribed by our physician(s). We will bill your pharmacy insurance and charge the applicable co-pay. **Please understand that you are not obligated to have prescriptions filled here and you have the option of receiving your medications from the pharmacy of your choice.** We would be happy to facilitate this for you. So that we have your complete information, please fill out the following information.

Drug Allergies: ☐ Yes Please list:_____ ☐ No

List of current medications (include strengths and prescribing physician, if known)

_____

_____

_____

_____

_____

Please provide your Prescription Insurance card to the receptionist so we have a copy on file (same insurance that is presented to a retail pharmacy).

Would you like to have your prescriptions filled at our office, when available? ☐ Yes ☐ No

If no, or if we are unable to fill a prescription for you, please list your preferred pharmacy:

Pharmacy Name_____

Address_____City_____State_____Zip_____

Phone_____ Fax_____

Does your prescription insurance require mail order for maintenance medications? ☐ Yes ☐ No

Your co-pay, if applicabable, is due upon receipt of any prescriptions or services. We accept various payment methods. Please ask our receptionist if you have any questions.

_____ _____
(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative) (Date)

_____ _____
(Printed Name) (Relationship to Patient)

Please bring all your current medications with you on your first visit so our physicians can thoroughly assess your regiments.