

PATIENT REGISTRATION

DATE: _____

PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)			ADDRESS	
CITY		STATE/ ZIP	BEST CONTACT # (SPECIFY CELL, HOME, WORK)	ALTERNATIVE #
DOB	AGE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> MARRIED TO _____ <input type="checkbox"/> SINGLE <input type="checkbox"/> OTHER _____	SOCIAL SECURITY #
EMAIL			OCCUPATION	
ETHNICITY <input type="checkbox"/> HISPANIC /LATINO <input type="checkbox"/> NOT HISPANIC/LATINO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINE TO STATE			PREFERRED LANGUAGE:	RACE: <input type="checkbox"/> DECLINE TO STATE
INSURED/RESPONSIBLE PARTY INFO		RELATION TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____ <u>*IF INSURED/RESPONSIBLE PARTY IS SELF SKIP TO INSURANCE INFORMATION</u>		
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)				
CLINICAL SUMMARY/SUMMARY OF CARE	<input type="checkbox"/> PRINT COPY <input type="checkbox"/> EMAIL			
PATIENT INFORMATION/REMINDERS	<input type="checkbox"/> PRINT COPY <input type="checkbox"/> EMAIL			

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 #: _____

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

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

HEALTH QUESTIONNAIRE & MEDICATIONS

PATIENT NAME:	DOB:	AGE:	HEIGHT/WEIGHT:	OCCUPATION:
ALLERGIES: (Name <u>AND</u> Reaction)				
MEDICAL HISTORY: <u>ex: diabetes, cancer, hypertension</u>		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): _____ <u>DO YOU TAKE STEROIDS SUCH AS PREDNISONE?</u> YES NO		REVIEW OF SYSTEMS CONTINUED: CIRCLE APPLICABLE CARDIOVASCULAR: 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: _____		
FAMILY HISTORY: INDICATE ANY MEDICAL ISSUES WITHIN YOUR IMMEDIATE FAMILY. (<u>if deceased, specify cause + age of death</u>)				
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: _____				

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 \geq 3mph
- **\geq 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: _____

AUA SYMPTOM SCORE

PATIENT NAME: _____

DATE: _____

For Questions 1-7 circle your response and write your score in the far right box.

1. Incomplete Emptying: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

2. Frequency: Over the past month, how often have you had to urinate again less than 2 hours after you previously urinated?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

3. Intermittency: Over the past month, how often have you found that you stopped and started again several times when you urinated?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

4. Urgency: Over the past month, how often have you found it difficult to postpone urination?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

5. Weak Stream: Over the past month, how often have you had a weak stream?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

6. Straining: Over the past month, how often have you had to push or strain to begin urination?

Not at all	Less than 1 out of 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
0	1	2	3	4	5	

7. Nocturia: How many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

Not at all	1 time	2 times	3 times	4 times	5 or more times	Your score
0	1	2	3	4	5	

Add up your scores for total AUA Score: _____

8. Quality of Life Due to Urinary Symptoms: If you were to spend the rest of your life with your urinary condition the way it is now, how would you feel about that?

Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
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SEXUAL HEALTH INVENTORY FOR MEN

(for patient to fill out)

PATIENT NAME: _____

INSTRUCTIONS:

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may choose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	No Sexual Activity	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory to you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5

Add up the total numbers from Questions 1-5: _____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

1-7 Severe ED	8-11 Moderate ED	12-16 Mild to Moderate ED	17-21 Mild ED
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SEXUAL HEALTH INVENTORY FOR MEN

(for patient's partner to fill out)

NAME: _____

RELATIONSHIP TO PATIENT: _____

INSTRUCTIONS:

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help your partner and his doctor identify if he may be experiencing erectile dysfunction.

Each question has several possible responses. Circle the number of the response that best describes your partner's situation. Please be sure that you select one and only one response for each question.

OVER THE PAST 6 MONTHS:

1. How do you rate your partner's confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
2. When your partner has had erections with sexual stimulation, how often were his erections hard enough for penetration?	No Sexual Activity	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
3. During sexual intercourse, how often was your partner able to maintain his erection after penetration?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain his erection to completion of intercourse?	Did Not Attempt Intercourse	Extremely Difficult	Very Difficult	Difficult	Slightly Difficult	Not Difficult
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory to you?	Did Not Attempt Intercourse	Almost Never or Never	A Few Times (less than half)	Sometimes (about half the time)	Most Times (more than half)	Almost Always or Always
	0	1	2	3	4	5

Add up the total numbers from Questions 1-5: _____

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

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