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## PATIENT INFORMATION SHEET

**\*\*\*Please Print & Complete Everything**

Patients Full Legal Name (F) \_\_\_\_\_ (M) \_\_\_\_\_ (L) \_\_\_\_\_

Alias/Maiden \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_ M \_\_\_\_ F \_\_\_\_

Current Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Billing Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Marital Status: Single      Married      Separated      Divorced      Widowed

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_

Patients Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

### Whom may we talk to in the event of an emergency?

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Number \_\_\_\_\_ Home Number \_\_\_\_\_

### Medical Power Of Attorney (If applies, provide copy)

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

### Executor of your Estate (If applies, provide copy)

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**Living will**                      yes or no                      If yes, please provide copy

### Insurance Information

Primary Insurance \_\_\_\_\_ **Insured** Party Full Legal Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Insured** Date of birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ **Insured** Party Full Legal Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Insured** Date of birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone # \_\_\_\_\_

Cross Streets \_\_\_\_\_

**PATIENT INFORMATION SHEET – Continued**

**Patients Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Please Initial next to each section:**

\_\_\_\_\_ I hereby agree to pay for services rendered when charges are incurred, unless previous arrangements have been made. In the event of default, I agree to pay any collections costs and/or attorney fees as may be required to effect collection of charges incurred.

\_\_\_\_\_ I hereby authorize PALO VERDE HEMATOLOGY-ONCOLOGY, LTD. to release any information acquired in the course of my examination or treatment. I also authorize photocopies of this form and my signature to be valid as the original.

\_\_\_\_\_ I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to PALO VERDE HEMATOLOGY-ONCOLOGY, LTD.

\_\_\_\_\_ I hereby authorize payment directly to PALO VERDE HEMATOLGY-ONCOLOGY, LTD for the surgical and/or medical benefits, if any, otherwise payable to me under terms of my insurance. I also guarantee that all the information I have provided is current and correct, and I understand that I am responsible for financial loss due to inaccurate/outdated information I provide.

\_\_\_\_\_ I will notify PALO VERDE HEMATOLOGY-ONCOLOGY, LTD. immediately with any insurance, address or contact information changes. Otherwise I will be held responsible for all actions incurred by inaccurate/outdated information.

\_\_\_\_\_ If eligibility of insurance cannot be verified, or if deductible, out of pocket or co-insurance has not been met, I understand that I will be responsible for the cost of all medical services rendered.

\_\_\_\_\_ I request that payment of authorized Medicare, Medicare HMO and all other plans benefits be made either to me or on my behalf to PALO VERDE HEMATOLOGY-ONCOLOGY, LTD for any services furnished to me by that physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I hereby authorize photocopies of this authorization and my signature to be as valid as the original.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF SPOUSE/ \_\_\_\_\_ DATE \_\_\_\_\_  
GUARANTOR

PATIENT NAME: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Your age: \_\_\_\_\_

Reason for your consultation today: \_\_\_\_\_

Please list all of the Physician's currently involved with your care for this visit, and/or to which physician's you want us to send copies of your visits:

Referring Physician:

1. \_\_\_\_\_

Primary Physician

2. \_\_\_\_\_

Other Physician

3. \_\_\_\_\_

Other Physician

4. \_\_\_\_\_

Other Physician

5. \_\_\_\_\_

### PAST MEDICAL HISTORY

Please list all surgeries and all hospitalizations:

Year:

Tonsillectomy	YES	NO	_____
---------------	-----	----	-------

Appendectomy	YES	NO	_____
--------------	-----	----	-------

Hernia Repair	YES	NO	_____
---------------	-----	----	-------

Hysterectomy	YES	NO	_____
--------------	-----	----	-------

Others (please list)			_____
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_____			_____
-------	--	--	-------

_____			_____
-------	--	--	-------

_____			_____
-------	--	--	-------

Other medical problems?

\_\_\_\_\_

\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Date: \_\_\_\_\_

SOCIAL HISTORY

Please circle one: Married Single Divorced Widowed

Occupation: \_\_\_\_\_

Religious preference: \_\_\_\_\_

Place of birth: \_\_\_\_\_

Military Service: \_\_\_\_\_

Do you smoke? YES NO If yes, how many packs a day? \_\_\_\_\_

If no, did you ever smoke? YES NO How many packs a day? \_\_\_\_ When did you quit? \_\_\_\_\_

How often do you drink alcoholic beverages?

Every day? YES NO Once a week? YES NO Once a month? YES NO Hardly ever?

YES NO

Have you ever used Marijuana? YES NO When? \_\_\_\_\_

Any other illegal drugs? YES NO

Please list:

\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_  
\_\_\_\_\_ When? \_\_\_\_\_

FAMILY HISTORY

	Alive	Deceased	Cause of Death	Age at death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Children	_____	_____	_____	_____

Do you have other family members with cancer?

YES NO

Please list:

Cause of Death Age at death

\_\_\_\_\_ Cause of Death \_\_\_\_\_ Age at death  
\_\_\_\_\_ Cause of Death \_\_\_\_\_ Age at death  
\_\_\_\_\_ Cause of Death \_\_\_\_\_ Age at death

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO When? \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Date: \_\_\_\_\_

PRESENT MEDICATION

Medication	Dose	Medication	Dose
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

LIST ALL ALLERGIES TO MEDICATIONS

Medicine	Type of reaction
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU HAVE A LIVING WILL?            YES   NO

FEMALE MEDICAL HISTORY

Age at first period? \_\_\_\_\_ Age at first pregnancy? \_\_\_\_\_

How many pregnancies? \_\_\_\_\_ How many live births? \_\_\_\_\_ How many miscarriages? \_\_\_\_\_

Did you breast feed? YES   NO

Have you used hormone replacement therapy (HRT) YES   NO   If yes, how long? \_\_\_\_\_

What year did you begin HRT? \_\_\_\_\_      What year did you stop? \_\_\_\_\_

Any complications with HRT?    YES   NO

If yes, please list complications:

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Advanced Beneficiary Notice  
(ABN)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Your physician has recommended certain Diagnostic Test (s). The purpose of this form is to help you make an informed decision about these services. You should read this entire notice carefully.

Our staff will make every attempt to obtain the appropriate authorization (s) that might be required by your insurance company. It is your responsibility to follow up with your insurance company and verify that the test (s) have been authorized and that you can proceed.

Please be aware, verbal authorizations from the insurance company are not a guarantee of payment and that ultimately you, the patient, will be responsible for the bill. Though the Physicians or PA's at our facility order your diagnostic test (s) we are not responsible for the payment of these bills if denied by your insurance carrier.

Your signature below acknowledges the above contents and that you understand this notice. You also acknowledge that you wish to proceed with the test (s) that has been ordered.

Patient Signature: \_\_\_\_\_

Signature of legal guardian for patient: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**PALO VERDE HEMATOLOGY /ONCOLOGY**

**GENERAL REVIEW OF SYSTEMS FORM:**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Review of Systems (Check all boxes that apply)

**GENERAL**

- weight loss
- fatigue
- fever
- night sweats
- loss of appetite

Y	N
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**ENDOCRINE**

- diabetes
- thyroid disease
- warmer than others

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**HEENT**

- headache
- dizziness
- hearing loss
- sinus problems
- mouth sores
- swallowing difficulty
- nosebleeds
- hoarseness
- cataracts

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**RESPIRATORY**

- cough
- shortness of breath
- wheezing
- asthma
- pleurisy
- coughing up blood

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**IMMUNITY**

- lymph node swelling
- pneumonia vaccine
- HIV infection

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**CARDIOVASCULAR**

- chest pain
- heart attack
- irregular heart beat

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**HEMATOLOGIC**

- bruising
- bleeding
- blood clot in legs/arms

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**GASTROINTESTINAL**

- nausea
- vomiting
- esophageal reflux
- ulcer
- constipation
- diarrhea
- blood in stool
- hepatitis
- colonoscopy, date: \_\_\_\_\_

Y	N
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**URINARY**

- frequency
- incontinence
- blood in urine
- night urination, # \_\_\_\_\_

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**MEN**

- prostate disorder
- sexual problems

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**WOMEN**

- first menstruation, age: \_\_\_\_\_
- menopause, age: \_\_\_\_\_
- last menstrual period, date: \_\_\_\_\_
- number of pregnancies: \_\_\_\_\_
- number of live births: \_\_\_\_\_
- number of miscarriages: \_\_\_\_\_
- Infertile?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**BONES & EXTREMITIES**

- bone pain/arthritis
- back pain
- osteoporosis
- swelling of ankles/feet

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**NEUROPSYCH**

- stroke/TIA
- seizures
- imbalance
- depression
- weakness

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**SKIN**

- rash
- itching

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**HEALTH CARE MAINTENANCE:**

Last PSA: \_\_\_\_\_ Last Colonoscopy: \_\_\_\_\_  
Last Pelvic Exam: \_\_\_\_\_ Last Mammogram: \_\_\_\_\_

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Tiffani J. Rollins, MS, PA-C  
Shannon McLean, PA-C  
William Resseguie, PA-C  
Susan Harding, NP-C  
Christine Douthit, PA-C

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Account: \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_

### HIPAA Acknowledgement

I received a copy of the Privacy Rules from *Palo Verde Hematology Oncology*, and authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to this office.

These people may receive my Protected Health Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Relationship to patient:  Spouse  Parent  Significant Other  Other \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Relationship to patient:  Spouse  Parent  Significant Other  Other \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Relationship to patient:  Spouse  Parent  Significant Other  Other \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Relationship to patient:  Spouse  Parent  Significant Other  Other \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Relationship to patient:  Spouse  Parent  Significant Other  Other \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Relationship to patient:  Spouse  Parent  Significant Other  Other \_\_\_\_\_

May we leave a detailed message regarding office visits and/or test results on your answering machine, home or cell?  YES  NO

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or parent/legal guardian if patient is a minor)