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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: _____

Who is your primary physician?

Name of physician who referred you to this office:

Your date of birth: _____

Your age: _____

Reason for your consultation today: _____

Questions for the physician: _____

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

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

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

Any other medical problems? _____

SOCIAL HISTORY

Please circle one: Married Single Divorced Widowed

Occupation: _____

Religious preference: _____

Place of birth: _____

PATIENT NAME: _____ Date: _____

FAMILY HISTORY

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

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 _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO When? _____

PRESENT MEDICATION

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

LIST ALL ALLERGIES TO MEDICATIONS

Medicine	Type of reaction
_____	_____
_____	_____

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? ____ Once a week? ____ Once a month? ____ Hardly ever? ____

DO YOU HAVE A LIVING WILL? YES NO



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"/>
<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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Prakash Thapaliya, M.D.
Manpreet Chadha, M.D.



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 #: _____
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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)