Overcoming Cancer Together

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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

Social Security # ______________________ Drivers License # ________________ State ___

Patients Employer ___________________________ Occupation _______________________

Address ____ Phone # ______________

Pharmacy ____ Phone # ______________

Cross Streets ____

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

Name _________________________ 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 # ______________

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

PALO VERDE CANCER SPECIALISTS

PATIENT NAME: ____

Today's Date: __________________________________

Who is your primary physician?

____

What physician referred you to this office?

____

Your date of Birth? ___________________

Your age: __________________

Reason for your consultation today: ______________________________________

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)

____ ______________

____ ______________

____ ______________

Other medical problems? ____

____

SOCIAL HISTORY

Please circle one: Married Single Divorced Widowed

Occupation: ____

Religious preference: ____

Place of birth: _____________________________

PATIENT NAME: ______________________________ DATE: ______________________

FAMILY HISTORY

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

Do you have other family members with cancer? YES NO

Please list any other family member and type of cancer:

____

____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO

If yes, When? ____

DO YOU HAVE A LIVING WILL? YES NO

Do you smoke? ____________ How many packs a day? ______

If NO, did you ever smoke? _____ 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? _____

PALO VERDE CANCER SPECIALISTS
GENERAL REVIEW OF SYSTEMS FORM: **Date:** ________________________
Name: ____

Review of Systems (Check all boxes that apply)

GENERAL	Y	N
weight loss		
fatigue		
fever		
night sweats		
loss of appetite		

ENDOCRINE	Y	N
diabetes		
thyroid disease		
warmer than others		

HEENT	Y	N
headache		
dizziness		
hearing loss		
sinus problems		
mouth sores		
swallowing difficulty		
nosebleeds		
hoarseness		
cataracts		

RESPIRATORY	Y	N
cough		
shortness of breath		
wheezing		
asthma		
pleurisy		
coughing up blood		

IMMUNITY	Y	N
lymph node swelling		
pneumonia vaccine		
HIV infection		

CARDIOVASCULAR	Y	N
chest pain		
heart attack		
irregular heart beat		

HEMATOLOGIC	Y	N
bruising		
bleeding		
blood clot in legs/arms		

GASTROINTESTINAL	Y	N
nausea		
vomiting		
esophageal reflux		
ulcer		
constipation		
diarrhea		
blood in stool		
hepatitis		
colonoscopy, date:__________		

URINARY	Y	N
frequency		
incontinence		
blood in urine		
night urination, #_________		

MEN	Y	N
prostate disorder		
sexual problems		

WOMEN	Y	N
first menstruation, age: ________		
menopause, age: _______		
last menstrual period, date: ______		
number of pregnancies: ________		
number of live births: ________		
number of miscarriages: ________		
Infertile?		

BONES & EXTREMITIES	Y	N
bone pain/arthritis		
back pain		
osteoporosis		
swelling of ankles/feet		

NEUROPSYCH	Y	N
stroke/TIA		
seizures		
imbalance		
depression		
weakness		

SKIN	Y	N
rash		
itching		

HEALTH CARE MAINTENANCE:

Last PSA:__________________________ Last Colonoscopy:___________________

Last Pelvic Exam:___________________ Last Mammogram:___________________

Diplomates, American Board of Medical Oncology / Hematology

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Tiffani Rollins, P.A.-C
William Resseguie, P.A.-C
Susan Harding, NP-C
Jessica Dende, P.A.-C

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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 ___________

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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)

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ACCNT #: _______________

Due to the implementation of our new electronic system, we now require the following information. Please assist us by answering the following questions:

ETHNICITY:

( ) Hispanic or Latino ( ) Not Hispanic or Latino

RACE:

( ) American Indian or Alaska Native

( ) Asian

( ) Black or African American

( ) Native Hawaiian or Other Pacific Islander

( ) Other

( ) White

PREFERRED LANGUAGE: (Please Print) ____

PREFERRED METHOD OF CONTACT: (Circle One)

PHONE (Please provide contact phone number) (______) ________---______________

MAIL

NAME: (Please Print) ____

EMAIL ADDRESS: ____

(This information will NOT be used as a method of contact.)