PALO VERDE
CANCER SPECIALISTS
Overcoming Cancer Together

Martin B. Langford, M.D.
Amol N.S Rakkar, M.D., CEO
Maqbool A. Halepota, M.D., F.A.C.P
Haider Zafar, M.D.
Demetrio Mamani, M.D.

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Sucai Bi, M.D., PhD
Saima Saeed, M.D.

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

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)			
_____			_____
_____			_____
_____			_____
_____			_____

TRANSFUSIONS

Have you ever had a blood transfusion? ☐ YES NO ☐ When? _____

Did you have a reaction to the transfusion ☐ YES NO ☐

If yes, what kind of reaction did you have? _____

DO YOU HAVE A LIVING WILL? ☐ YES NO ☐

PATIENT'S NAME: _____ Date: _____

MEDICATION (please list)

Medication	Dose	How long used?
1.		
2.		
3.		
4.		
5.		
6.		

LIST ALL ALLERGIES TO MEDICATIONS

Medicine	Type of reaction

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:

_____

_____

FAMILY HISTORY

	Medical problems	Cause of Death	Age at death
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

PATIENT NAME: _____ Date: _____

Do you have other family members with cancer? YES ☐ NO ☐
Breast Cancer? YES ☐ NO ☐ What family member? _____ When? _____
Colon Cancer? YES ☐ NO ☐ What family member? _____ When? _____
Ovarian Cancer? ☐ YES NO ☐ What family member? _____ When? _____
Please list any other family member and type of cancer:

_____

_____

_____

SOCIAL HISTORY

Please circle one: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Occupation: _____
Religious preference: _____
Place of birth: _____ How long in Arizona: _____

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? _____

Palo Verde Cancer Specialists

Name: _____ **Date:** _____

Review of Systems (Check all boxes that apply)

	Y	N
GENERAL		
weight loss	☐	☐
fatigue	☐	☐
fever	☐	☐
night sweats	☐	☐
loss of appetite	☐	☐
ENDOCRINE		
diabetes	☐	☐
thyroid disease	☐	☐
warmer than others	☐	☐
HEENT		
headache	☐	☐
dizziness	☐	☐
hearing loss	☐	☐
sinus problems	☐	☐
mouth sores	☐	☐
swallowing difficulty	☐	☐
nosebleeds	☐	☐
hoarseness	☐	☐
cataracts	☐	☐
RESPIRATORY		
cough	☐	☐
shortness of breath	☐	☐
wheezing	☐	☐
asthma	☐	☐
pleurisy	☐	☐
coughing up blood	☐	☐
IMMUNITY		
lymph node swelling	☐	☐
pneumonia vaccine	☐	☐
HIV infection	☐	☐
CARDIOVASCULAR		
chest pain	☐	☐
heart attack	☐	☐
irregular heart beat	☐	☐
HEMATOLOGIC		
bruising	☐	☐
bleeding	☐	☐
blood clot in legs/arms	☐	☐

	Y	N
GASTROINTESTINAL		
nausea	☐	☐
vomiting	☐	☐
esophageal reflux	☐	☐
ulcer	☐	☐
constipation	☐	☐
diarrhea	☐	☐
blood in stool	☐	☐
hepatitis	☐	☐
colonoscopy, date:_____	☐	☐
URINARY		
frequency	☐	☐
incontinence	☐	☐
blood in urine	☐	☐
night urination, #_____	☐	☐
MEN		
prostate disorder	☐	☐
sexual problems	☐	☐
WOMEN		
first menstruation, age: _____	☐	☐
menopause, age: _____	☐	☐
last menstrual period, date: _____	☐	☐
number of pregnancies: _____	☐	☐
number of live births: _____	☐	☐
number of miscarriages: _____	☐	☐
Infertile?	☐	☐
BONES & EXTREMITIES		
bone pain/arthritis	☐	☐
back pain	☐	☐
osteoporosis	☐	☐
swelling of ankles/feet	☐	☐
NEUROPSYCH		
stroke/TIA	☐	☐
seizures	☐	☐
imbalance	☐	☐
depression	☐	☐
weakness	☐	☐
SKIN		
rash	☐	☐
itching	☐	☐

HEALTH CARE MAINTENANCE:

Last PSA:_____

Last Pelvic Exam:_____

Last Colonoscopy:_____

Last Mammogram:_____

Diplomates, American Board of Medical Oncology / Hematology

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Sucai Bi, M.D., PhD
Saima Saeed, M.D.

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 __________

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)

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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.)