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.
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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

PALO VERDE CANCER SPECIALISTS

PATIENT NAME:_____
TODAY'S DATE:_____
Physician who referred you:_____
Primary Care Physician:_____
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:

(Name) (Specialty) (Phone Number)

1. _____
2. _____
3. _____
4. _____
5. _____

PAST MEDICAL HISTORY

Medical conditions(s) that you are currently being treated for, or have been treated for in the past:

1. _____
2. _____
3. _____
4. _____
5. _____

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PATIENT NAME:_____
TODAY'S DATE:_____

PRESENT MEDICATIONS:

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

LIST ALL ALLERGIES TO MEDICATIONS:

Medicine	Type of reaction	Approximate Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGICAL HISTORY:

			Year:
Mastectomy	YES ☐	NO ☐	_____
Lung Surgery	YES ☐	NO ☐	_____
Biopsy	YES ☐	NO ☐	_____
Hysterectomy	YES ☐	NO ☐	_____
Others (please list)			
_____			_____
_____			_____
_____			_____

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PATIENT NAME:_____
TODAY'S DATE:_____

SOCIAL HISTORY:

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

Occupation: _____

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? ____

Did you ever use illegal drugs? Yes☐No☐If yes, what kind? _____
When? _____

Have you ever or do you currently use Marijuana? Yes☐No☐
When? _____

FAMILY HISTORY:

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

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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

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.)