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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: _____

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

			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:

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:

Palo Verde Cancer Specialists

Name: _____

Date: _____

Review of Systems (Check all boxes that apply)

GENERALweight loss
fatigue
fever
night sweats
loss of appetite

Y

N

ENDOCRINEdiabetes
thyroid disease
warmer than others

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

RESPIRATORYcough
shortness of breath
wheezing
asthma
pleurisy
coughing up blood

IMMUNITYlymph node swelling
pneumonia vaccine
HIV infection

CARDIOVASCULARchest pain
heart attack
irregular heart beat

HEMATOLOGICbruising
bleeding
blood clot in legs/arms

GASTROINTESTINALnausea
vomiting
esophageal reflux
ulcer
constipation
diarrhea
blood in stool
hepatitis
colonoscopy, date: _____

Y

N

URINARYfrequency
incontinence
blood in urine
night urination, # _____

MENprostate disorder
sexual problems

WOMENfirst menstruation, age: _____
menopause, age: _____
last menstrual period, date: _____
number of pregnancies: _____
number of live births: _____
number of miscarriages: _____
Infertile?

BONES & EXTREMITIESbone pain/arthritis
back pain
osteoporosis
swelling of ankles/feet

NEUROPSYCHstroke/TIA
seizures
imbalance
depression
weakness

SKINrash
itching

HEALTH CARE MAINTENANCE:

Last PSA: _____

Last Pelvic Exam: _____

Last Colonoscopy: _____

Last Mammogram: _____



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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

Overcoming Cancer Together

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 _____

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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)



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.)