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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: \_\_\_\_\_

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. \_\_\_\_\_

## PALO VERDE CANCER SPECIALISTS

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:

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

## PALO VERDE CANCER SPECIALISTS

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

**Palo Verde Cancer Specialists**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Review of Systems (Check all boxes that apply)

**GENERAL**weight loss  
fatigue  
fever  
night sweats  
loss of appetite

Y


N


**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



**GASTROINTESTINAL**nausea  
vomiting  
esophageal reflux  
ulcer  
constipation  
diarrhea  
blood in stool  
hepatitis  
colonoscopy, date: \_\_\_\_\_

Y


N


**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: \_\_\_\_\_



*Overcoming Cancer Together*

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Demetrio Mamani, M.D.  
Nazish Ahmad, DO  
Rajinder Grover, MD

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)



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.)