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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?

Name of physician 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	_____
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Hernia Repair	YES	NO	_____
---------------	-----	----	-------

Hysterectomy	YES	NO	_____
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Others (please list)			_____
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Any 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: Cause of Death Age at death

_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES NO When? _____

PRESENT MEDICATION

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

LIST ALL ALLERGIES TO MEDICINES

Medicine	Type of reaction
_____	_____
_____	_____

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?

Once a day? _____ Once a week? _____ Once a month? _____ Hardly ever? _____

DO YOU HAVE A LIVING WILL? YES NO

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****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: _____**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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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: _____
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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.)