



Michiana Hematology Oncology, PC

Patient Information				
Patient's Last Name:		First:	Middle:	Nickname (what you like to be called):
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid		
Social Security Number:		Date of Birth:	Age:	
Street Address:		City:	State:	Zip Code:
Home Phone:	Mobile Phone:		Email Address:	
Emergency Contact:		Phone:	Relationship:	
Preferred Means of Contact for Appointment Reminders: <input type="checkbox"/> Phone/Voice mail <input type="checkbox"/> Email <input type="checkbox"/> Both				
City of Birth:		Race/Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other		
Occupation:		Employer:		
Employer's Address:			Employer's Phone:	
Retired: <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, retired from:			
Do you live in an assisted living residence or nursing home? <input type="checkbox"/> Y <input type="checkbox"/> N				
Name of facility _____ Address _____				
City _____ State _____ Zip Code _____ Phone _____				

Spouse's Information					
Spouse's Last Name:		First:	Middle:	Date of Birth:	Social Security Number:
Employer:		Employer's Address:		Employer's Phone:	
Retired: <input type="checkbox"/> Y <input type="checkbox"/> N		If yes, retired from:		Mobile Phone:	

Special Information
Is there any additional information we should know when providing your care?

Physician	
1. Primary Physician:	
2. Referring Physician:	
3. Surgeon:	
4. Other	
5. Other	

Primary Insurance Information			
If patient is not the policyholder, the Policyholder Information section below must be filled out.			
Insurance Company:		Effective Date:	
Policy Holder:	Certificate Number:	Group Number:	Member Number:

Secondary Insurance Information			
If patient is not the policyholder, the Policyholder Information section below must be filled out.			
Insurance Company:		Effective Date:	
Policy Holder:	Certificate Number:	Group Number:	Member Number:

Additional Insurance Information			
If patient is not the policyholder, the Policyholder Information section below must be filled out.			
Insurance Company:		Effective Date:	
Policy Holder:	Certificate Number:	Group Number:	Member Number:

Policyholder Information				
If patient is not the policyholder, this section must be filled out.				
Last Name:	First:	Middle:	Address is Same as Patient's: <input type="checkbox"/> Y <input type="checkbox"/> N	
Street Address:		City:	State:	Zip Code:
Date of Birth:	Social Security Number:	Home Phone:	Mobile Phone:	
Relation to Patient	Employer:	Employer's Address:		
Employer's: City, St, Zip			Employer's Phone:	

Medical History			
Reason for Today's Visit:			
Normal Weight:	Current Weight:	Weight Gain/Loss Amount:	Duration of Gain/Loss:

Current Medications		
Medication	Frequency	Purpose of Medication
Please list all allergies to medications, food, or other:		
1.	4.	7.
2.	5.	8.
3.	6.	9.

Previous Cancer History				
Year	Diagnosis Or Site	Chemotherapy (list medications)	Radiation	Surgery
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous Surgeries		
Year:	Surgery Performed:	Hospital:

Personal Health History (check all that apply)			
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> High Blood	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Polyps of Colon	<input type="checkbox"/> Depression	<input type="checkbox"/> Breast Lumps
<input type="checkbox"/> Pneumonia or TB	<input type="checkbox"/> Cancer	<input type="checkbox"/> Skin Infection	<input type="checkbox"/> Urinary Infections
<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Anemia	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Asbestos Exposure	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Current Health State: (check all that apply)			
<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Pain
<input type="checkbox"/> Fever	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Bleeding from Nose
<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Bruising	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Visual Changes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Prone to Sunburn
<input type="checkbox"/> Changes in Moles/Freckles		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
Do you exercise: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> daily <input type="checkbox"/> weekly			

History of Tobacco and Alcohol Use (All Patients)	
Do you drink: <input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> daily <input type="checkbox"/> frequently (several times a week) <input type="checkbox"/> socially (few times a month)? For how many years? _____	
Do you smoke: <input type="checkbox"/> Y <input type="checkbox"/> N	Do you use smokeless tobacco: <input type="checkbox"/> Y <input type="checkbox"/> N
How many packs a day: _____ for how many years _____ if you quit what year _____	
Would you like to quit? <input type="checkbox"/> Y <input type="checkbox"/> N	

Family History of Cancer: (please list all relatives diagnosed with cancer)			
Relationship	Type of Cancer	Age at Diagnosis	Deceased From Cancer
			<input type="checkbox"/> Y: Age _____ <input type="checkbox"/> N
			<input type="checkbox"/> Y: Age _____ <input type="checkbox"/> N
			<input type="checkbox"/> Y: Age _____ <input type="checkbox"/> N
			<input type="checkbox"/> Y: Age _____ <input type="checkbox"/> N
			<input type="checkbox"/> Y: Age _____ <input type="checkbox"/> N

Colorectal Screening (All Patients)
Has your colon ever been examined by colonoscopy or sigmoidoscopy? <input type="checkbox"/> Y <input type="checkbox"/> N
How many polyps were found : <input type="checkbox"/> None <input type="checkbox"/> One <input type="checkbox"/> 2-10 _____ 11-25 _____ <input type="checkbox"/> More than 25 _____

Prostate Cancer Screening (Male Patients)	
Have you ever had a PSA (Prostate Specific Antigen) blood test?	<input type="checkbox"/> Y <input type="checkbox"/> N
If so, has the result of the PSA been evaluated?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever had a digital rectal exam?	<input type="checkbox"/> Y <input type="checkbox"/> N
If so, has your digital rectal exam result ever been abnormal?	<input type="checkbox"/> Y <input type="checkbox"/> N

Menstrual Period History (Female Patients)		
Age of 1 st Menstrual Period: _____	Are you still having menstrual periods?	<input type="checkbox"/> Y <input type="checkbox"/> N
How long ago was your most recent menstrual period? <input type="checkbox"/> Less than 1 month ago <input type="checkbox"/> 1-6 months ago <input type="checkbox"/> 7-11 months ago <input type="checkbox"/> 1 year ago or longer		
If you have not had your period in more than 1 year, how old were you at your last period? _____		
Why did your periods stop? <input type="checkbox"/> Natural menopause <input type="checkbox"/> Surgery to remove ovaries or uterus <input type="checkbox"/> Chemotherapy or medical treatment		

Pregnancy History (Female Patients)	
Have you ever been pregnant	<input type="checkbox"/> Y <input type="checkbox"/> N
How many times have you been pregnant?	
How many times have you given birth to a live baby	
How old were you the first time you gave birth to a live baby?	
How old were you the last time you give birth to a live baby?	

History of Hormone Use (Female Patients)	
Have you ever taken birth control hormones?(i.e. pill, patch, injection)	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you currently taking birth control hormones?	<input type="checkbox"/> Y <input type="checkbox"/> N
In total, how many years have you taken birth control hormones?	
Have you ever taken medication to increase your chance of becoming pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
In total, how many months did you take medication to become pregnant	
Have you ever taken Hormone Replacement Therapy (HRT)?	<input type="checkbox"/> Y <input type="checkbox"/> N
If so, how long did you take HRT?	
Have you ever taken Tamoxifen (Nolvadex®)?	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, please check one: <input type="checkbox"/> for treatment of cancer or DCIS <input type="checkbox"/> for prevention of cancer	
How many years did you take Tamoxifen (Nolvadex®)? _____	

Breast Cancer Screening (Female Patients)	
Do you examine your own breasts for lumps?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever detected a lump?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever had a mammogram of your breasts? Date of last mammogram _____.	<input type="checkbox"/> Y <input type="checkbox"/> N
How old were you the first time you had a mammogram?	
How often do you have a mammogram? <input type="checkbox"/> Once every _____ years <input type="checkbox"/> once each year <input type="checkbox"/> more than once a year?	
How many breast biopsies have you had in your lifetime? _____	
Have you ever been diagnosed with any of the following breast conditions? Check all that apply. <input type="checkbox"/> ADH (atypical ductal hyperplasia) Age: _____ <input type="checkbox"/> ALH (atypical lobular hyperplasia) Age: _____ <input type="checkbox"/> LCIS (lobular carcinoma in situ) Age: _____	

Breast Cancer Screening (Female Patients) continued	
Have you ever been diagnosed with breast cancer?	<input type="checkbox"/> Y <input type="checkbox"/> N
At what age were you first diagnosed with breast cancer?	
If diagnosed with breast cancer, was it in one or both breasts? <input type="checkbox"/> One <input type="checkbox"/> Both <input type="checkbox"/> Right <input type="checkbox"/> Left	

Notice of Privacy Practices

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES.**

Date: _____ **Initial:** _____

Consent to Treat

I request and give consent to my physician to provide and perform such medical/surgical care, test, procedures, medications and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial: _____

Release of Medical Information and Authorization to Pay Insurance Benefits

I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial: _____

Medicare Certification

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

Initial: _____

Financial Agreement

I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Initial: _____

Advanced Directive	
Do you have a living will? <input type="checkbox"/> Y <input type="checkbox"/> N A copy may be required for your chart. A copy was received by this office. Date: _____	
Have you appointed a Health Care Representative ? <input type="checkbox"/> Y <input type="checkbox"/> N Read and sign below. I give my consent and authorization for the person or persons listed below to act as my Health Care Representative to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I also give my consent and authorization for the person, or persons to be notified any time that I have an appointment. I also understand that I may revoke this privilege at any time by submitting my request in writing to this office.	
Name of Health Care Representative: _____	Date: _____
Name of Health Care Representative: _____	Date: _____
Signed by: _____	Date: _____
Witnessed by: _____	Date: _____

Release of Protected Health Information Via Telephone to Answering Machine or Voice Mail	
I give my consent and authorization for the medical or billing staff of my physician's office to leave Protected Health Care Information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.	
Number: _____	Initial: _____

Release of Protected Health Information To Others				
I give my consent and authorization for the medical or billing staff of my physician's office to release Protected Health Care Information about me or for me to the people that I have listed below. I understand that I may revoke this privilege at any time by submitting my request in writing to this office.				
First Name:	Last Name:	Relationship:	Phone:	Mobile Phone:
1.				
2.				
3.				
4.				

Patient's Signature: _____ Date: _____
 Parent/Guardian Signature: _____ Date: _____