Please fill all forms out in **black ink** as these documents will be scanned into your patient chart. Remember to arrive **15 minutes** before your scheduled appointment time to be sure all information is completed before you see the doctor.

HEMATOLOGY & ONCOLOGY ASSOCIATES
PATIENT REGISTRATION

Today's Date ______________________________

PATIENT INFORMATION

Name ______________________________
Address ______________________________
____
E-mail Address ______________________________
Employer/School ______________________________
Address ______________________________
Employer/School Phone ______________________________

Patient Account # ______________________________
Date of Birth ______________________ Sex ________
Social Security # ______________________________
Telephone Home ______________________________
Cell ______________________________
Patient Status: ___ Employed ____ Student (F / P) _____
______ Married _____ Single Other ______________

Phone # for Appointment Reminder Calls ______________________________

INSURED INFORMATION

Please present your insurance cards at the front desk when you check in.

______ Patient is insurance subscriber

______ Insurance subscriber other than patient.

Please fill out the information below for the insurance subscriber if other than patient.

Subscriber Name ______________________________
Subscriber Date of Birth ______________________________
Subscriber Address ______________________________
____
Social Security # ______________________________

Relationship to Patient ______________________________
Subscriber Employer Name ______________________________
____
ID/Policy # ______________________________
Group Name ______________ Group # __________

OTHER COVERAGE

Insured ______________________________
Subscriber Insurance Co. ______________________________
Group Name ______________ Group # __________

Relationship to Patient ______________________________
Subscriber Date of Birth ______________________________
ID/Policy # ______________________________

Referring Physician ______________________________

• • • • • • • • • • • • • • • • • • •

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process my claims (s).

____
Patient or Authorized Person

I hereby authorize payment directly to **HEMATOLOGY & ONCOLOGY ASSOCIATES NE PA, PC,** federal ID# 23-2137083, of my insurance benefits for medical care rendered by any physician associated with this group. **I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY DEDUCTIBLE, COINSURANCE, OR NON-COVERED SERVICES**

______________________________ (Insured or Authorized Person)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503

FOR OFFICE USE ONLY
MEDICAL RECORD #__________

HEMATOLOGY & ONCOLOGY ASSOCIATES OF NORTHEASTERN PA, PC

Please complete this form & bring it with you to your appointment.

Name ______________________________ Date of Birth __________

What is the reason for today's visit? ______________________________

What do you hope is accomplished during today's visit? ______________________________

Referring Physician ______________________________ Visit Date __________

Present Family Doctor ______________________________ Since __________

Previous Family Doctor ______________________________

Personal Past Medical History – Do you have any history of:
(Please indicate all conditions present and month/year diagnosed)

	Present	Month/Year
Acid Reflux (GERD)	____	______
Alcohol Abuse	____	______
Anemia	____	______
Type ____________		
Angina	____	______
Anxiety	____	______
Bladder Infections (UTI)	____	______
Bleeding Disorder	____	______
Specify ____________		
Blood Disorder	____	______
Low Blood Counts	____	______
Specify ____________		
High Blood Counts	____	______
Specify ____________		
Blood Transfusions	____	______
Why? ____________		
Cancer	____	______
Specify Type ____________		
Cardiac Arrhythmias	____	______
Colonic Polyps	____	______
Colonic Tumors	____	______
Congestive Heart Disease	____	______
(CHF, Cardiomyopathy)		
Coronary Artery Disease	____	______
Crohn's Disease	____	______
CVA (Stroke)	____	______
Degenerative Joint Disease (DJD)	____	______
Depression	____	______
Diabetes	____	______
Associated Kidney Disease	____	______
Associated Eye Disease	____	______
Associated Neuropathy	____	______
Diverticulitis	____	______
Diverticulosis	____	______
DVT/Deep Vein Thrombosis	____	______

	Present	Month/Year
(Blood Clot)		
Eye Disease (Please Specify)	____	______
Glaucoma	____	______
Macular Degeneration	____	______
Retinal Tear	____	______
Other (Specify) ____________		
Gallbladder Disease (Gallstones)	____	______
Goiter	____	______
Gout	____	______
Graves Disease	____	______
Headaches (Please specify)	____	______
Tension	____	______
Migraine	____	______
Cluster	____	______
Other/Unknown	____	______
Heart Murmur	____	______
Hepatitis	____	______
Hereditary Defect	____	______
Specify ____________		
Hiatal Hernia	____	______
HIV/AIDS	____	______
Hyperlipidemia (High Cholesterol)	____	______
Hypertension (High Blood Pressure)	____	______
Hyperthyroid (High Thyroid)	____	______
Hypothyroid (Low Thyroid)	____	______
Inflammatory Bowel Disease	____	______
Irritable Bowel Syndrome	____	______
Jaundice	____	______
Liver Disease (example:.Cirrhosis)	____	______
Specify ____________		
Lung Disease (Please Specify)	____	______
Asthma	____	______
COPD	____	______
Emphysema	____	______
Other (Specify) ____________		

FOR OFFICE USE ONLY
MEDICAL RECORD #______________

Myocardial Infarction (Heart Attack) ______ __________
Neuropathy ______ __________
Specify____
Osteoarthritis ______ __________
Osteoporosis ______ __________
Pancreatitis ______ __________
Peptic Ulcer Disease ______ __________
Peripheral Vascular Disease ______ __________
Psychiatric Disease ______ __________
Specify ____
Pulmonary Embolism(Blood Clot Lung)______ __________
Rheumatic Fever ______ __________
Renal Failure (Kidney Failure) ______ __________
Cause ____
Renal Stones (Kidney Stones) ______ __________
Renal Disease Other (Kidney Disease) ______ __________
Specify____
Seizure Disorder ______ __________
Sexually Transmitted Disease ______ __________
Skin Disorder (Specify) ______ __________
Acne/Rosacea ______ __________
Eczema ______ __________
Psoriasis ______ __________
Other (Specify) ______ __________
TIA (Mini Stroke) ______ __________
Trauma/Fracture ______ __________
Specify____
Tuberculosis ______ __________
Exposure to Tuberculosis only______ __________
Valvular Heart Disease (heart Murmur)______ __________
Other Medical Condition ______ __________
Specify ____
____

Have you been tested for HIV? ____Yes ____No

Female

Age of first menstrual period ________
Age of first live birth ________
Date of last menstrual period ________
Menstrual period length ________
Number of pregnancies ________
Number of live births ________
Number of miscarriages ________
Date/Age of menopause ________
Any hormonal supplement/birth control use?
____Yes ____No
Specify type/length
____
Date of last mammogram (Mo/Day/Yr)____________
Date of last pap smear (Mo/Day/Yr)____________

Male

Testicular Disease
(specify)____________________
Prostate Disease
(specify)____________________
Last PSA (Mo/Day/Yr) ________
Last prostate exam (Mo/Day/Yr) ________

Routine Screening

Last Colonoscopy (Mo/Day/Yr) ________
Vaccines (Mo/Day/Yr) of last administration
Flu ______ Pneumovax ________
Pertussis ______ Polio ________
Hepatitis B______ HPV ________
Tetanus ______ MMR ________
Last Cholesterol Screen (Mo/Day/Yr) ________
Last Bone Density (Mo/Day/Yr) ________

Do you have a history of any allergies to medications? ☐Yes ☐No
If so, what medications are you allergic to and in what year did the allergy occur?____________________
If so, what happens when you take the medicine (i.e. rash, shortness of breath, nausea)____________________
Do you have any other allergies such as hay fever, etc.? ____________________

Please list all medications which you are currently taking, along with dose, frequency, & also length of time on medication. Include all over the counter medications and vitamins. If unable to fit all medications, you may attach a list.

Medication Name	Dose/Strength	Times taken per day	Who Prescribes	Why do you take this?

FOR OFFICE USE ONLY
MEDICAL RECORD #______________

Pharmacy Name:____

Address:____

City________________________ State______ Zip__________

PLEASE TELL US ABOUT:

Previous Hospitalizations:

Date	Location	Reason

Previous Surgeries

	Performed	Mo/Day/Year
Amputation	______	______
Specify__________		
Appendectomy	______	______
Arthroscopic Surgery	______	______
Specify__________		
Bone Marrow Biopsy	______	______
Bone Marrow Transplant	______	______
Biopsy	______	______
(Specify Breast, skin, ect.)______________		
Bronchoscopy	______	______
Cataract Surgery	______	______
Cholecystectomy	______	______
Colon Resection	______	______
Colonoscopy	______	______
Colposcopy	______	______
Cystectomy	______	______
Cystoscopy	______	______
C-section	______	______
Coronary artery bypass	______	______
Dental Extraction	______	______
G/PEG-tube placement	______	______
Hernia Repair	______	______
Hickman Catheter	______	______
Hysterectomy	______	______
IVC Filter	______	______

	Performed	Mo/Day/Year
Lung(or pulmonary)resection	______	______
Mastectomy (Left/right)	______	______
Melanoma Removal	______	______
Orthopedic Surgery	______	______
Specify__________		
Ovarian Tumor Removal	______	______
Paracentesis	______	______
Partial Mastectomy	______	______
Left/Right__________		
Plastic Surgery	______	______
Specify__________		
Port-a-cath	______	______
Prostate Gland Removal	______	______
Salpingo-oopherectomy	______	______
Stent Placement	______	______
Thoracentesis	______	______
Tonsillectomy	______	______
Total Hip Replacement	______	______
Left/Right__________		
Total Knee Replacement	______	______
Left/Right__________		
Tubal Ligation	______	______
TURP	______	______
Vasectomy	______	______

Other______________________________

Social History:

Do you use tobacco? ☐ Yes ☐ No If so, what kind (cigarettes, cigars, etc.): ______________________

How many years:__________ How many packs per day?__________________

If you do not currently use tobacco, have you ever smoked? ☐ Yes ☐ No

When did you quit smoking? ____________________

How many years:________ How many packs per day?________

Does anyone in your household smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes, how frequently________ If yes, what kind (beer, liquor, etc): ______________

Have you used recreational drugs? ☐ Yes ☐ No

If yes, what kind: (marijuana, cocaine, etc)._________________________

FOR OFFICE USE ONLY
MEDICAL RECORD #______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower
If married, health of spouse?____
Do you live alone? ☐ Yes ☐ No
If not, who do you live with? ____
How many children do you have? ______________________
Do you care for anyone else in your home? ☐ Yes ☐ No
What is your current activity level?
☐ Sedentary ☐ Occasional Exercise ☐ Light Exercise ☐ Exercise Daily
Are you currently on any special diets? ☐ Regular diet ☐ Low Cholesterol ☐ Diabetic ☐ Other__________________
Ethnicity: ☐ Hispanic or Latino Origin ☐ Not of Hispanic or Latino Origin
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander
☐ Black or African-American ☐ White ☐ More than one race (check all that apply)
Religious beliefs we should be aware of? ____

Work History:
Are you currently: ☐ Working ☐ Retired Date:____________ ☐ Disabled Date: ______________
Present Occupation or if retired, Previous Occupation: ____
Previous Occupations: ____
Have you ever been exposed to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Other: ____________________
Have you had any foreign travel in the last year? ☐ Yes ☐ No

Family Medical History: (If more space is needed, please use reverse side of paper.)

Family Member	Sex	Disease(s)	Age	If deceased, cause & age of death
Father				
Mother				
Siblings 1.				
2.				
3.				
4.				
Children 1.				
2.				
3.				
Extended family with and history of disease (please indicate Maternal/Paternal)				
Spouse				
Grandparents				
Aunts				
Uncles				
Cousins				

Review of Systems

Do you have any problems with any of the following? Please check all that apply.

General
- ☐ Fatigue
- ☐ Weakness
- ☐ Trouble sleeping
- ☐ Weight loss
- ☐ Weight gain

Skin
- ☐ Rashes
- ☐ Dryness
- ☐ Color changes
- ☐ Hair/Nail Changes
- ☐ Changing skin lesion
- ☐ Skin ulcers

Head
- ☐ Headache
- ☐ Head Injury

Eyes/Ears/Nose/Throat
- ☐ Blurry or double vision
- ☐ Eye Pain
- ☐ Blindness
- ☐ Ear Pain
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Sore throat/hoarseness
- ☐ Mouth sores

Cardiac
- ☐ Palpitations
- ☐ Chest pain
- ☐ Chest pain
  - ☐ with activity
  - ☐ with breathing
  - ☐ with movement
  - ☐ all the time

Respiratory
- ☐ Wheezing
- ☐ Shortness of breath with normal activity
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath lying flat
- ☐ Cough-wet, dry, productive (circle if applies)
- ☐ Coughing up blood

FOR OFFICE USE ONLY
MEDICAL RECORD #______________

Circulation

- ☐ Discoloration of feet/legs
- ☐ Sores/ulcers on feet/legs
- ☐ Swelling of ankles/legs
- ☐ Calf pain when walking
- ☐ Leg cramps
- ☐ Varicose veins

Gastrointestinal

- ☐ Difficulty swallowing
- ☐ Pain when swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Black bowel movements
- ☐ Loss of bowel control
- ☐ Abdominal pain
- ☐ Abdominal bloating

Genitourinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Loss of bladder control
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Nocturia (urinating at night)

Musculoskeletal

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Back pain

Nervous System

- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness/tingling (where?)______________
- ☐ Headache
- ☐ Weakness L/R side
- ☐ Paralysis
- ☐ Recent falls
- ☐ Change in walking ability

Metabolism/Endocrine

- ☐ Heat or cold intolerance
- ☐ Excessive Sweating
- ☐ Increased Thirst
- ☐ Change in Appetite
  - ☐ Increase
  - ☐ Decrease
- ☐ Recent unexplained weight changes

Hematology

- ☐ Unexplained fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Ease of bruising
- ☐ Ease of bleeding
- ☐ Tender or swollen lymph nodes

Psychiatric

- ☐ Nervousness
- ☐ Memory loss
- ☐ Stress
- ☐ Bipolar disorder
- ☐ Other psychological diagnosis______________
- ☐ Depression
- ☐ Confusion

Women Only

- ☐ Currently Pregnant
- ☐ Breastfeeding currently
- ☐ Hot flashes
- ☐ Vaginal discharge
- ☐ Irregular menses
- ☐ Breast mass
- ☐ Breast pain

Do you have any medical problems that you believe may limit your life to less than 1 year?

____

Do you have regular pain? ☐ Yes ☐ No
If yes, where is your pain? ____
Do you take any medications to relieve pain? ☐ Yes ☐ No
List medications and frequency. Is it effective?

Medication	Dose	Frequency	Effective?

Pain Scale: **0 is no pain** and **10 is the worst pain** you have ever had:

What is your pain right now?	0	1	2	3	4	5	6	7	8	9	10
In the last 30 days, what was your pain at its best?	0	1	2	3	4	5	6	7	8	9	10
In the last 30 days, what was your pain at its worst?	0	1	2	3	4	5	6	7	8	9	10

How frequent is your pain? ☐ Constant ☐ Intermittent Explain______________________
How long does it last? ☐ Less than 1 hour ☐ Less than one day ☐ All day ☐ All night
Is your pain getting: ☐ Better ☐ Worse ☐ Not Changing

FOR OFFICE USE ONLY
MEDICAL RECORD # ___________

Activity	Worsens Pain	Relieves Pain	No Effect on Pain	Activity	Worsens Pain	Relieves Pain	No Effect on Pain
Sitting				Standing			
Rising from sitting				Driving			
Walking				Coughing/Sneezing			
Bending forward				Lying on your side			
Bending backward				Lying on Back			

____
Patient's Signature

____
Physician's Signature

____
Today's Date

____
Physician's Assistant/Nurse Practitioner