GREAT LAKES CANCER CARE
PATIENT INFORMATION

Name _____ Primary Physician _____
(Last) (First) (M.I.)
Nickname/preferred first name_____OB/GYN Physician _____

Address _____
Street City Zip
Birth date _____ SS #: _____ Sex: M F Marital Status S M W D

Home Phone_____ Work phone _____ Cell:_____ E- mail:_____

Great Lakes Cancer Care may use the above contact information to confirm and/or communicate with you.

Student_____ Full Time/Part time Retirement Date _____ Retired from _____

Employer _____ Occupation _____

Spouse's name _____ Birth date _____

Employer _____ Occupation _____

Pharmacy Name/Location _____

Emergency Contact _____ Address _____ Phone _____

Relationship to patient: _____

B. RESPONSIBLE PARTY: _____ (Check if same as patient information and skip to item C.)

Name _____
(Last) (First) (M.I.)
Address _____
Street City Zip
Birth date _____ SS# _____ Home Phone _____ Work Phone _____

_____

C. REFERRAL SOURCE: ____ Primary Physician ____ Personal Referral ____Other Physician _____

____ Internet ____ Talking Phone Book ____ Verizon ____ Other (please specify) _____

_____

D. INSURANCE INFORMATION

Primary Insurance _____ Insurance ID # _____ Group _____

Subscriber Name (skip if same as responsible party) _____
Person that holds the policy
Secondary Insurance Name and Address _____

Subscriber's Name _____ Date of Birth _____

Subscriber's SS# _____ Subscriber's Employer _____ Plan Name _____

GREAT LAKES CANCER CARE
MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____

RACE (Optional): Caucasian_____ African American_____ Hispanic_____ Native American_____ Alaskan Native _____ Asian_____

ALLERGIES: Please list any medicines, foods, or other substances to which you are ALLERGIC:

_____

_____

Do you have an allergy to latex? YES NO

CURRENT DAILY MEDICATIONS: Please list any medications, including non-prescription drugs and birth control pills that you have taken in the last three months. _____

_____

Smoker	YES	NO	Former smoker	YES	NO
Alcohol	YES	NO	Former alcohol use	YES	NO
Recreational drugs	YES	NO	Former recreational drug use	YES	NO

Have you ever been hospitalized for any type of surgery? Please list: YES NO

_____

Have you ever been hospitalized for any condition that did NOT require surgery? YES NO
Please list:

_____

Patient mobility/ambulation: No restrictions Limited Walker Wheelchair

Do you have, or have you ever had any of the following conditions or problems?

1. Diabetes YES NO

2. Cancer YES NO
   If yes, site of cancer _____Year diagnosed _____

   Are you currently receiving radiation or chemotherapy treatment? YES NO

3. Are you receiving treatment for any other type of abnormal growth or tumor? YES NO

4. Kidney or bladder problems including stones, infections, etc. ? YES NO

5. Thyroid problems? YES NO

6. Stomach or intestinal problems; including ulcers or colitis? YES NO

7. Blood disorders; including anemia or abnormal bleeding? YES NO

8. Liver problems; including hepatitis, contact with a person with hepatitis, yellow jaundice, yellow skin or eyes, or cirrhosis? YES NO

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MEDICAL HISTORY

9. Neurologic problems; seizures, multiple sclerosis, Parkinsons, or problems with your balance, vision, or hearing? YES NO

If yes, please specify: _____

10. Heart problems; heart murmur, high blood pressure, chest pain, shortness of breath, heart attack, angina, or rheumatic fever? YES NO

11. Do you have an automatic defibrillator or any other cardiac device? YES NO
If yes, circle type:

Pacemaker Intracardiac defibrillator Biventricular intracardiac defibrillator

12. Lung problems; asthma, emphysema, bronchitis, pneumonia, or exposure to tuberculosis? YES NO

13. Do you have sleep apnea? YES NO

14. Do you have any medical condition not mentioned above? If so, explain below. YES NO

15. Do you need to premedicate before procedures? YES NO

16. Are you claustrophobic? YES NO

17. Is this visit for a Worker's Compensation claim or a work related injury? YES NO
If yes, please ask receptionist for a Worker's Compensation form.

18. If you are over 50 years of age, have you had a colonoscopy? YES NO
If yes, when was this done?_____

19. If you are female, is there any chance you may be pregnant? YES NO

20. Are you nursing at this time? YES NO

21. Have you had a Pap smear in the last year? YES NO

22. If you are female and over 50 years of age, have you had mammography in the past 27 months? YES NO

23. If you are female and over 60 years of age, have you had a bone scan? YES NO
If yes, when was this done?_____

24. Is there a family history of:

	YES	NO	FAMILY MEMBER
Tuberculosis	____	____	_____
Cancer (specify site)	____	____	_____
Diabetes	____	____	_____
High blood pressure	____	____	_____
Heart disease	____	____	_____

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21. Do you have children? ____ ____ How many? _____

What brings you to our office today?_____

_____

Other relevant information and/or concerns you would like the doctor to be aware of, including any questions you would like answered: _____

_____

GREAT LAKES CANCER CARE
CONSENT

Please sign in the five areas as indicated.

CONFIRMATION OF MEDICAL HISTORY
I have read the questions on pages 1, 2, and 3 and have completed them truthfully and to the best of my ability.

_____ _____
Required Signature of Patient and/or Responsible Party Date

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR MEDICARE/INSURANCE BILLING
I request that payment of authorized Medicare and/or other insurance company benefits be made on my behalf for any services furnished me by Great Lakes Cancer Care, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and/or other insurance companies and their agents any information needed to determine these benefits or benefits for related services.

_____ _____
Required Signature of Patient and/or Responsible Party Date

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND/OR HEALTH CARE OPERATIONS
I hereby consent to the use and disclosure of my Protected Health Information by Great Lakes Cancer Care for purposes of treatment, payment and/or healthcare operations. I hereby consent to the use and disclosure of my Protected Health Information by Great Lakes Cancer Care to arrange for treatment by another provider or for the referral of another provider or entity, including a Business Associate of Great Lakes Cancer Care, and for business operations Great Lakes Cancer Care or its related treatment entities.

I understand that my signature on the consent is required in order for me to receive care from the Physician Practice and that the Physician Practice may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for its treatment, payment and health care operations.

_____ _____
Required Signature of Patient and/or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I understand that further information on the Physician Practice's uses and disclosures of my Protected Health Information is included in the Physician Practice's Notice of Privacy Practices. I acknowledge receipt of Great Lakes Cancer Care's Notice of Privacy Practices.

_____ _____
Required Signature of Patient and/or Responsible Party Date

CONSENT FOR MEDICAL RECORD PHOTOGRAPHY
I hereby consent to having my photograph taken as part of my medical record. The taking of the photography will assist Great Lakes Cancer Care, in the identification of patients and will assist in eliminating record misidentification. This photograph will be part of my medical record and shall remain strictly confidential to the same extent as my patient records remain confidential under Great Lakes Cancer Care's policy and New York State Law.

_____ _____
Required Signature of Patient and/or Responsible Party Date