

# Associates in Oncology/Hematology, P.C.

TODAY'S DATE:

PAGE

OF

ROCKVILLE

KENSINGTON

SIGN: 1/2/26/2000

**Please sign in upon arrival. You will be called in the order of your scheduled appointment time.**

Please check the box under the name of the Doctor, PA, or Service you are here for today.

	PATIENT NAME	ARRIVAL TIME								
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
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16.										
17.										
18.										
19.										
20.										

SAMPLE  
 NOT FOR  
 REPRODUCTION

Dr. XXXXXXXXX

Dr. XXXXXXXXX

Dr. XXXXXXXXX

Dr. XXXXXXXXX

Dr. XXXXXXXXX

Dr. XXXXXXXXX

P.A. - XXXXXXXX

P.A. - XXXXXXXX  
X

NURSE ONLY

LAB ONLY

INFUSION



# New Patient Information

NP-INFO2:9/20/2001

Date Called  Initials  MD  Acct. No.

Appt. Date  Time  @  Rock.  Kens. Date Packet Sent  / By

(Insurance) Last Name  First  MI

Alternate Name(s)

Address  Apt. #

City  State  Zip Code

M/F  Marital Status

Home Phone  Work Phone

Date of Birth  Social Security Number

Person Making Appt.  Relationship  Phone

Next of Kin  Relationship  Phone

Primary Insurance

ID #  Group

Phone  Fax #

Secondary Insurance

ID #  Group

Phone #  Fax #

\*Self Referral  Yes  No **NOTE: If Yes, Need Release of Records Authorization**

Dx  Date of Onset

Primary Care MD  Phone

(If 1 Year or Less)  
Previous Primary MD  Phone

Referring Doctor  Phone

Surgeon  Phone

Surgery  Location

**Radiology** CT  Location

MRI  Location

US  Location

X-Ray  Location

Other

Hospital Name  ADM Date  DSCH Date

Hospital DX  Admitting MD

Other Pert Med Conditions

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Sr. Marie O'Dowd, R.N., P.A.-C  
Dianne M. Kube, Practice Administrator

Dear New Patient,

We would like to take this opportunity to welcome you to **Associates in Oncology and Hematology**. Your visit has been scheduled and for your convenience an appointment card has been attached.

Please complete the enclosed registration form and health questionnaire and bring them with you to your first appointment. In addition, the following items will be needed:

- list of current medications
- insurance card(s)
- referral form (if required by your insurance)
- method of payment (we accept cash, check, VISA, or MasterCard)

Prior to your appointment our new patient coordinator will be calling your primary and referring doctors to secure past medical records. These are needed for continuity of care. In some cases, your primary physician may require a signed medical release form and one has been included for your convenience. Please sign and forward this form to your primary doctor. You may make copies, if needed, for additional requests from other health care providers. We appreciate your cooperation in requesting these records.

To help you feel more comfortable with our specialty an office guide is attached. This form will assist you with questions and concerns which may arise during your treatment at AOH.

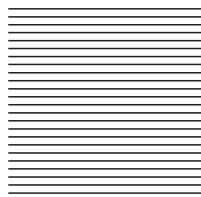
Our staff will be happy to accommodate your needs, but we ask that you please help us by alerting the front desk staff to any changes with your insurance, address or phone numbers.

If you have any questions, please do not hesitate to call before your appointment. We look forward to participating in your medical care.

Sincerely,

*The Physicians and Staff of AOH*

PAT-NEW:12/15/2000



Shady Grove Medical Building  
Suite 300  
9707 Medical Center Drive  
Rockville, MD 20850  
**(301) 424-6231**

Concord Building  
Suite 300  
10605 Concord Street  
Kensington, MD 20895  
**(301) 929-0765**



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Shady Grove Medical Building  
9707 Medical Center Drive, Suite 300  
Rockville, MD 20850  
(301) 424-6231 • Fax: (301) 294-4648

PATIENT'S ACCOUNT NUMBER

## PATIENT REGISTRATION (PLEASE PRINT)

Date / /	Patient's Last Name	First Name (Legal) & Middle Initial
-------------	---------------------	-------------------------------------

Address: Street	City	State	Zip
-----------------	------	-------	-----

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone ( )	Work Phone ( )	Date of Birth / /	Social Security No. -	Marital Status
--	----------------	----------------	----------------------	-----------------------	----------------

Referred By

Occupation

Employer's Address

State ZIP Code Phone: ( )

Emergency

Relationship Home Phone ( ) Work Phone ( )

Name of Spouse Next Relative or Friend

Relationship Home Phone ( )

Spouse's Employer Name

Address City State ZIP Code Phone: ( )

Primary Insurance Co. Name Address Effective Date I.D./Contract No. Group No.

Name of Policyholder (Address, if different from Patient)

Patient's Relationship to Policyholder  
 Self  Spouse  Child  Other

Secondary Insurance Co. Name Address Effective Date I.D./Contract No. Group No.

Name of Policyholder (Address, if different from Patient)

Patient's Relationship to Policyholder  
 Self  Spouse  Child  Other

Financially Responsible Person Last Name Home Phone ( ) Work Phone ( )

Address

### Patient Authorization

I request that payment of authorized Medicare/Insurance Carrier benefits be made on my behalf to Associates in Oncology/Hematology for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I understand that I am fully responsible for obtaining any necessary referrals required by my Insurance Carrier and that these must be presented at the time of service. I can exercise my right to be seen without a referral, but must pay for all services in full at the time of service. All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

**PLEASE RETURN THIS COMPLETED FORM WITH YOUR INSURANCE CARDS TO THE RECEPTIONIST THANK YOU.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**MEDICAL INFORMATION**

1. Have you recently had:	<b>YES</b>	<b>NO</b>
Loss of appetite .....	_____	_____
Weight loss .....	_____	_____
Fever .....	_____	_____
Chills .....	_____	_____
Sweating at night .....	_____	_____
Headaches .....	_____	_____
Trouble with your vision .....	_____	_____
Bleeding from your nose or gums .....	_____	_____
Hoarseness .....	_____	_____
Shortness of breath .....	_____	_____
Cough .....	_____	_____
Sputum production .....	_____	_____
Pleurisy .....	_____	_____
Chest pain .....	_____	_____
Palpitations or rapid heart beats .....	_____	_____
Ankle or leg swelling .....	_____	_____
Nausea or vomiting .....	_____	_____
Swelling in your abdomen .....	_____	_____
Abdominal cramps or pain .....	_____	_____
Change in bowel habits .....	_____	_____
Blood in stool .....	_____	_____
Passage of dark urine or light stools .....	_____	_____
Frequent urination .....	_____	_____
Waking up at night to urinate .....	_____	_____
Burning on urination .....	_____	_____
Back or flank pain .....	_____	_____
Blood or pus in urine .....	_____	_____
Lightheadedness .....	_____	_____
Black out spells .....	_____	_____
Fatigue .....	_____	_____
Periods of confusion .....	_____	_____
Excessive sleepiness .....	_____	_____
Numbness or tingling in arms or legs .....	_____	_____
Pain in your arms or legs .....	_____	_____

2. Have you ever had:	<b>YES</b>	<b>NO</b>
Mumps .....	_____	_____
Tuberculosis .....	_____	_____
Lung infections – pneumonia, bronchitis, asthma .....	_____	_____
Heart disease .....	_____	_____
High blood pressure .....	_____	_____
Stomach or duodenal ulcers .....	_____	_____
Liver disease (jaundice, hepatitis) .....	_____	_____
Gallstones .....	_____	_____
Kidney stones or infections .....	_____	_____
Stroke .....	_____	_____
Anemia .....	_____	_____

**MEDICAL INFORMATION (Continued)**

**YES NO**

- Easy bruising . . . . . \_\_\_\_\_
- Prolonged bleeding after dental extraction or surgery . . . . . \_\_\_\_\_
- Blood transfusions . . . . . \_\_\_\_\_
- Transfusion reaction . . . . . \_\_\_\_\_
- An allergic reaction to any medicine . . . . . \_\_\_\_\_
- Exposure to toxic chemicals . . . . . \_\_\_\_\_

3. Do you: **YES NO**

- Smoke cigarettes? . . . . . \_\_\_\_\_
- Smoke cigars or a pipe? . . . . . \_\_\_\_\_
- Drink alcoholic beverages daily? . . . . . \_\_\_\_\_

4. List date of your most recent:

- Complete physical examination . . . . . \_\_\_\_\_
- Pelvic examination . . . . . \_\_\_\_\_
- Chest x-ray . . . . . \_\_\_\_\_
- EKG . . . . . \_\_\_\_\_
- Pap smear . . . . . \_\_\_\_\_

5. List all medications you are currently taking

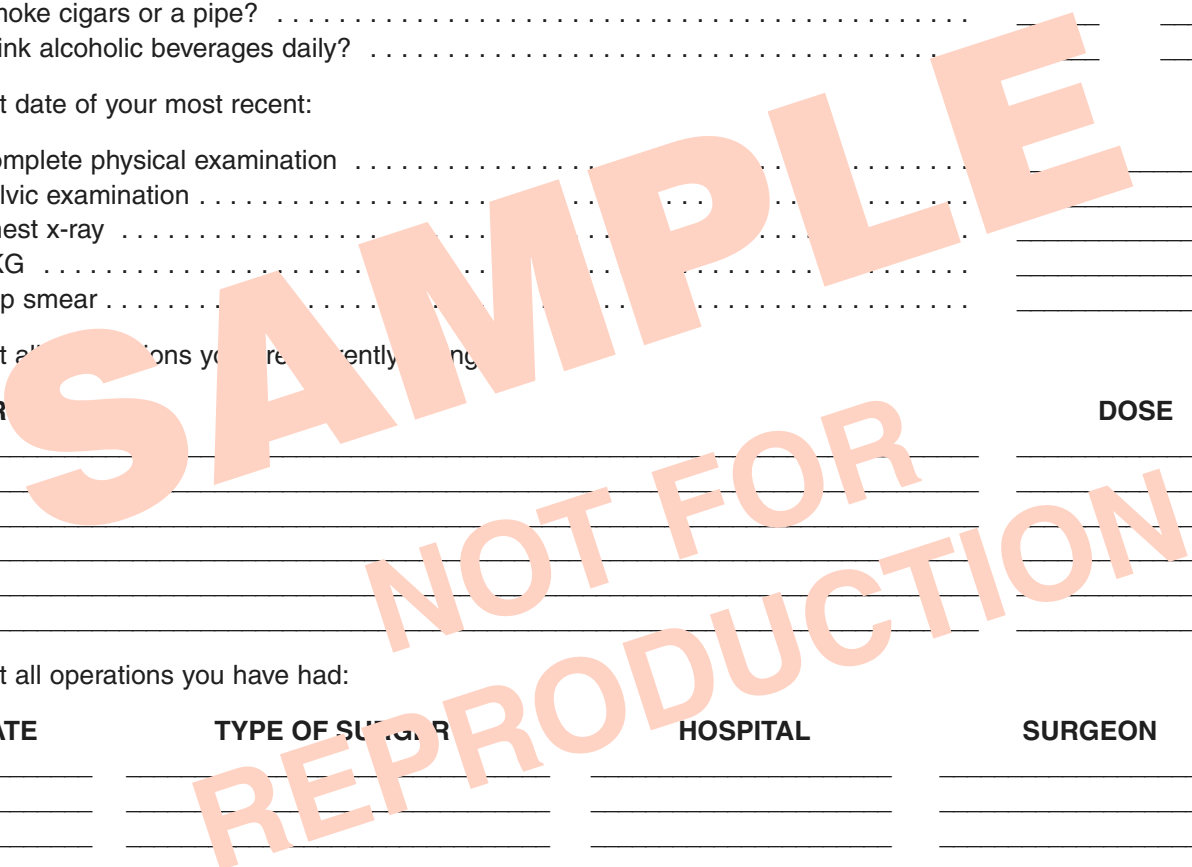
DR	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. List all operations you have had:

DATE	TYPE OF SURGERY	HOSPITAL	SURGEON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Menstrual History (Women only)

- Age of onset of periods . . . . . \_\_\_\_\_
- Number of pregnancies . . . . . \_\_\_\_\_
- Number of liveborn children . . . . . \_\_\_\_\_
- Number of miscarriages . . . . . \_\_\_\_\_
- Age of menopause . . . . . \_\_\_\_\_
- Have you ever had abnormal vaginal bleeding? . . . . . \_\_\_\_\_
- Have you ever had a D&C? . . . . . \_\_\_\_\_



**MEDICAL INFORMATION (Continued)**

8. Family History	Age	Past Illnesses	Current state of health or cause of death
Parents:			
Mother .....	_____	_____	_____
Father .....	_____	_____	_____
Siblings:			
Sister .....	_____	_____	_____
.....	_____	_____	_____
.....	_____	_____	_____
Brother .....	_____	_____	_____
.....	_____	_____	_____
.....	_____	_____	_____

Has any of your relatives had a history of:	YES	NO
Diabetes Mellitus .....	_____	_____
Tuberculosis .....	_____	_____
Allergies .....	_____	_____
High Blood Pressure .....	_____	_____
Heart .....	_____	_____
Go .....	_____	_____
Ane .....	_____	_____
Bleeding diso .....	_____	_____
Canc .....	_____	_____
Breast cysts .....	_____	_____

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## RELEASE OF MEDICAL RECORDS

I, \_\_\_\_\_, do hereby authorize  
\_\_\_\_\_  
to provide in writing to Associates in  
Oncology/Hematology a report of my diagnosis, treatment, prognosis and recommen-  
dations well as other data pertinent to his/her treatment of me during the time I was  
under his/her care.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

MED-REL:10/9/2000

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