Antietam Oncology & Hematology Group, PC

Patient Information					
Last Name:	First Name, Middle Initial:		Social Security #		Date of Birth:
Street Address:	City:		State	Zip Code:	
County of Residence:	Home Phone #	Cell Phone #	Gender M F	Marital Status: S M W D	
Email:					
Language:	Ethnicity: _____Hispanic/Latin ____ Other_____ ____Not Hispanic/Latino ___Prefer Not to Answer		Race: ____African American ____White ___Asian ___Hawaiian ___Other_____		
Patient Occupation:	Patient Employer		Employer Phone:		
Employer Address:	City:		State:	Zip Code:	
Retired:____ Yes ____No	If Yes, Retired From:				
Emergency Contact/Next of Kin	Relationship to Patient:	Home Phone #	Cell Phone #		
Street Address:	City:		State:	Zip Code:	

Insurance Information			
Primary Insurance:	Policy Holder Name:	Date of Birth:	Relationship to you
Policy #/ Social Security #	Group #	Effective Date:	
Secondary Insurance:	Policy Holder Name:	Date of Birth	Relationship to you
Policy #/ Social Security #	Group #	Effective Date:	

Do you have a prescription Plan? ____No _____ Yes Name of Company:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I, _____ request that payment of Medicare/Commercial insurance company benefits be made on my behalf to Antietam Oncology & Hematology Group for any services that have been rendered to me. All regulations pertaining to Medicare/Commercial Insurance assignment of benefits will apply.

I authorize Antietam Oncology and Hematology Group to release any medical information or other information about me that is necessary to submit claim forms, letters of medical necessity or any other requested information to the Social Security Administration, Health Care Financing Administration, CMS, or any insurance carrier.

I understand that if I am covered by Medicare or Commercial Insurance that Antietam Oncology and Hematology agrees to accept assignment of benefits and I am responsible for copays and coinsurance. We reserve the right to collect deductibles at the time of services rendered.

Signed:_____ Date:_____

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Physicians	
Primary Physician:	
Referring Physician:	
Surgeon:	
Other	
Other	

Children							
Do you have children:	____Yes	Age:____	Age:____	Age:____	Age:____		
	____No	Sex:_____	Sex:____	Sex:____	Sex:____		

History of Tobacco and Alcohol Use		
Do you drink: ____Yes ____No	How Often: ____ Frequently (Several times a week) ____Daily ____ Socially (Few times a month	How many years:
Please classify smoking status:	___Current every day smoker ___Former smoker ___ Current some day smoker ___ Never a smoker	
How many packs a day:	Do you use smokeless tobacco? ____Yes ___No	
What year did you start:	If you quit, what year:	

Current Health State: (check all that apply)			
___ Loss of Appetite	___Fatigue	___ Chest Pain	___ Headaches
___ Change in moles/freckles	___Fever	___ Constipation	___ Hot flashes
___Shortness of breath	___ Night Sweats	___Diarrhea	___ Bruising
___ Coughing up blood	___ Weight loss	___Nausea/Vomiting	___ Blood Clots
___ Bleeding from nose	___ Weight Gain	___ Rectal Bleeding	___ Other:
___ Prone to Sunburn	___Vision Change	___ Dizziness	___Other:
___ Blood in Urine	___Muscle Weakness	___Other:	___Other:

Personal Health History (check all that apply)			
___ Heart Disease	___Kidney Disease	___ Osteoporosis	___ Thyroid Disease
___ High Blood Pressure	___Broken Bones	___ Stroke	___ Diabetes
___Uriniary Infections	___ Polps of Colon	___Depression	___ Breast Lumps
___ Pneumonia or TB	___ Cancer	___ Skin Infection	___ Arthritis
___ Sinus Infection	___ Anemia	___ Seizures	___ Hepatitis
___ Asbestos Exposure	___ Pacemaker	___ Other:	___Other:

Previous Surgeries		
Year:	Surgery Performed:	Hospital/Facility

Family History (please list all relatives diagnosed with cancer)			
Relationship	Type of Cancer	Age of Diagnosis	Deceased from Cancer
			___Yes Age:____ __No
			___Yes Age:____ __No
			___Yes Age:____ __No
			___Yes Age:____ __No
			___Yes Age:____ __No

List of Medications

Please Print Information in the Appropriate Areas

Patient Name:_____

Local Pharmacy:_____ Phone #:_____
Address (If Known:)_____

Mail Order Pharmacy: _____ Phone #:_____
Address (If Known):_____

Please list all Allergies to medications		

Please list current medications (prescribed and Over the Counter)		
Medication	**Dosage**	**Frequency**