Antietam Oncology and Hematology Group, PC

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Hagerstown, MD 21740

☎(301)797-8279
Fax(301)797-8504

Dear Patient,

Welcome to Antietam Oncology and Hematology Group! We are a patient centered practice specializing in the diagnosis and treatment of cancer and blood disorders. We truly value the relationship with your Primary Care Provider, and we will work with you and your PCP to coordinate your care. Please be sure to bring the name of your PCP, as well as any other specialist you see on a regular basis with you to your appointment.

Enclosed, you will find the new patient questionnaire, which will provide us with essential information about your current health state and any medical conditions, as well as family history. Please complete all the paperwork before your visit, so your doctor will be prepared to review all information with you. Please be sure to have your insurance cards, pharmacy cards, identification card, as well as referrals if needed, to your appointment.

Please be aware that the patient portal and emailing is for matters that are not time sensitive, such as prescription refills, lab and tests results, appointment reminders and pre-appointment instructions. Matters that are urgent, emergent, or highly sensitive or include personal care are not suited for email. Please feel free to contact our office with any questions.

Thank You for choosing our practice!

Sincerely,

Antietam Oncology and Hematology Group

Patient Demographics

Patient Name: _____ **Gender:** ____

Date of Birth: _____ **SSN:** _____ **Marital Status** _ M _ S _ W _ D

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

E-mail: _____

Race: __ American Indian/ Alaskan __ Asian __ Black/ African American

__ Pacific Islander/ Hawaiian __White __ Multi-racial Other: _____

Ethnicity: __ Hispanic/Latino __ Not Hispanic/ Latino __ Other: _____

Preferred Language: __ English __ Spanish __ Other: _____

Employer: _____ **Occupation:** _____

__ Full-time __ Part-time __ Not employed __ Retired __ Military __ Disabled

Employer Address: _____ __ N/A __ Retired

Work Phone: _____ __ N/A

Spouse/ Next of Kin

Name: _____ **Gender**: _____
Relationship: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone: _____ **Cell Phone:** _____

Emergency Contact: *please list someone that is <u>not</u> in your household*

Name: _____ **Gender**: _____
Relationship: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone: _____ **Cell Phone:** _____

Medical History

Women Only

Age of menstruation onset: ___ Number of Pregnancies: ___ Age of 1st Pregnancy: ___

Number of live births: _____ [] Vaginal Delivery [] C- section

Are you taking birth control? ____ If yes, what kind: _____

Are you taking any hormones? ____ If yes, what kind: _____

How many days do your menstrual cycles last? _____

Date of last menstrual cycle: _____

Date of last pap test: _____ Have you had any abnormal pap test: _____

If so, how was it treated: _____

Date of last mammogram: _____ Do you get yearly mammograms: _____

Surgical History Summary: *please list all previous surgeries below*

Date of Surgery	Surgery	Reason	Facility/Surgeon

Medical History Continued

Social History

Tobacco Use:
Do you smoke? __ Yes __ No
Please indicate all types of tobacco products you have *ever* used:

__ Cigarettes/Cigar __ Pipe

__ Chewing tobacco __ Snuff

How many years have you used tobacco products?
_____

If you smoke(d) Cigarettes:

Packs per day: _____
Age you began smoking: _____
Age you quit smoking: _____
Currently a smoker: _____

____ Every day _____ Some days

Have you been exposed to second hand smoke?

__ Yes __ No

If yes, how many years? _____

Alcohol/Recreational Drugs/Tanning:

Have you ever consumed alcohol?

__ Yes __ No

How many drinks per week? _____

Do you use any street/recreational drugs? _____
If yes, what kind? _____ How often? _____

Have you used a Tanning bed? _____
How often? _____
Do you wear sunscreen? _____

Living Arrangements:

__ Alone __ Nursing Home Facility __ Spouse

__ Relative __ Assisted Living Facility __ Family

__ Other

Do you have an emotional support system? _____
If *yes*, with whom? _____

Are you being hurt or frightened by anyone in your life?

__ Yes __ No

If *yes*, by whom? _____

Transportation:

___ Ambulance __ Friend/Family

__ Bus __ Self Other: _____

Work History:

__ Working Full-Time __ Working Part-Time

__ Retired __ Disabled __ Unemployed

Are you lifting more than 10 lbs. at work or home? _____

Are you exposed to environmental hazards? _____

Medical History Continued

Personal History

Venous Access Devices:	**Fall Risk:**
Do you currently have: ___ PICC ___ Port ___ Dialysis access ___ Hickman Other: _____ ___ None	Do you use an assistive device to walk? _____ Are you unsteady on your feet? _____ Have you fallen in the past year? _____ **Assistive Devices:** ___ Walker ___ Wheelchair ___ Cane Other: _____

Cancer Family History

	Cancer Type	Age at diagnosis	Age at death	Death caused by cancer?
Mother				
Father				
Brother				
Sister				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Uncle				
Aunt				
Cousin				

Medical History Continued

Review of Systems: *please check all that apply*

Heart/Circulation Health:

___ None

___ Chest Pain

___ Poor circulation

___ Dizziness

___ Palpitations

___ Swelling of ankles or feet

___ Other

Stomach/Bowel Health:

___ None

___ Colonoscopy, year of most recent: _____

___ Difficulty passing your stool

___ Watery loose stool

___ Constipation

___ Loss of control of bowels

___ Excess gas or belching

___ Belly pain

___ Upset Stomach

___ Vomiting

Constitutional:

___ Weight Loss ___ Fever ___ Change In appetite

___ Fatigue ___ Night Sweats ___ Other

Vision, Hearing and Throat Health:

___ None ___ Cloudy Vision

___ Change in vision ___ Hearing Loss

___ Glasses/Contacts ___ Voice Change

___ Spots or floaters ___ Sore Throat

___ Problems swallowing ___ Other

Lung Health:

___ None ___ Home Oxygen

___ Chronic Coughing ___ Wheezing

___ Coughing up mucus ___ Other

___ Coughing up blood ___Shortness of breath

Brain Health:

___ None ___ Multiple Sclerosis

___ Chronic Headaches ___ Stroke

___ Confusion ___ Weakness

___ Numbness in fingertips

___ Alzheimer's ___ Other

___ Parkinson's Disease

___ Mini Stroke

___ Loss of feeling/movement

Medical History Continued

Review of Systems Continued: *please check all that apply*

Skin Health:

___ None
___ Psoriasis
___ New skin growths
___ Annual skin screening
___ Changes in moles
___ Severe sunburn
___ Rashes
___ Other

Urinary Health:

___ None
___ Other
___ Leaking of urine/dribbling
___ Urinating often
___ Burning with urination
___ Change in force or strain of urination
___ Blood in urine
___ Kidney problems

Musculoskeletal:

___ None
___ Arthritis
___ Muscle Weakness
___ Fibromyalgia
___ Joint Swelling
___ Bone Pain
___ Joint stiffness
___ Other
___ Back pain

Diabetes/Thyroid Health:

___ None

___ Diabetes (if yes, please select the following)

- ___ Diet Controlled
- ___ Insulin Controlled
- ___ Type 1
- ___ Type 2
- ___ Goiter
- ___ Related to medication
- ___ Diabetic during pregnancy

___ Thyroid condition (if yes, please select the following_

- Overactive Thyroid
- Underactive Thyroid

Mental Health State:

___ None
___ Anxious
___ Feeling sad most of the time
___ Treated for Mental Health Issues
___ Recent loss or life change
___ Had suicidal thoughts
___ Difficulty sleeping/ Sleep disturbance

What is your stress level? _____

Are you currently under the care of someone?

If so, whom are you seeing? _____

If no, would you like to be? _____

Medical History Continued

Review of Systems Continued: *please check all that apply*

Blood Disorders/Infections Disease:

___ None

___ Below/Above normal amount of red blood cells

___ Clotting/bleeding disorder

___ History of blood transfusion

___ Reaction to a blood transfusion

___ Hepatitis A ___ Hepatitis B ___ Hepatitis C

___ Genital Herpes ___ HIV/AIDS___ Herpes Zoster

___ Human Papilloma Virus (HPV)

___ Vancomycin Resistance Enterococci (VRE)

___ Methicillin Resistant Staphylococcus Aureus (MRSA)

___Mumps ___ Measles ___ Chicken Pox

___ Polio

___ Rheumatic Fever

___ Other: _____

Diet:

___ Don't feel hungry/loss of appetite

___ Unplanned weight gain ____ pounds

___ Unplanned weight loss ____ pounds

___ Difficulty chewing/swallowing

___ Other _____

Female Reproductive Health:

___ Not applicable

___ Currently sexually active

___Breast Lumps

___ Nipple Discharge

___ Abnormal vaginal bleeding

___ Vaginal discharge ___ Fertility issues

___ Hot flashes ___ None

___ Leaking urine ___ Other

___ Painful intercourse

Male Reproductive Health:

___ Not applicable

___Prostate exam, date last done: _____

___ PSA blood test, date last done: _____

___ Enlarged prostate

___ Able to acquire an erection

___ Able to maintain an erection

___ Discharge from penis

___ Pain/swelling in the testicle(s)

___ Currently sexually active

___ Fertility issues

___ Other:

Medical History Continued

Past and Current Cancer treatment

When were you diagnosed with cancer? _____ What type? _____

Initial symptoms: _____

What testing did you have done? _____

What surgeries and/or biopsies have been done? _____ When? _____

Have you had prior radiation therapy? ____ Yes ____ No

If *yes*, when and to what part of your body? _____

What facility did you have radiation? _____ What year? _____

Name of Radiation Oncologist who consulted you: _____

Have you had chemotherapy or biotherapy? ____ Yes ____ No

If *yes*, when did you have it? _____ What year? _____

Name of chemotherapy or biotherapy you had: _____

Name of Oncology Physician who prescribed you chemotherapy: _____

Have you participated in a Clinical Trial? ____ Yes ____ No

If *yes*, which trial? _____ Where was this trial done? _____

Have you had a Bone Marrow Transplant (Allogenic or Autologous)?

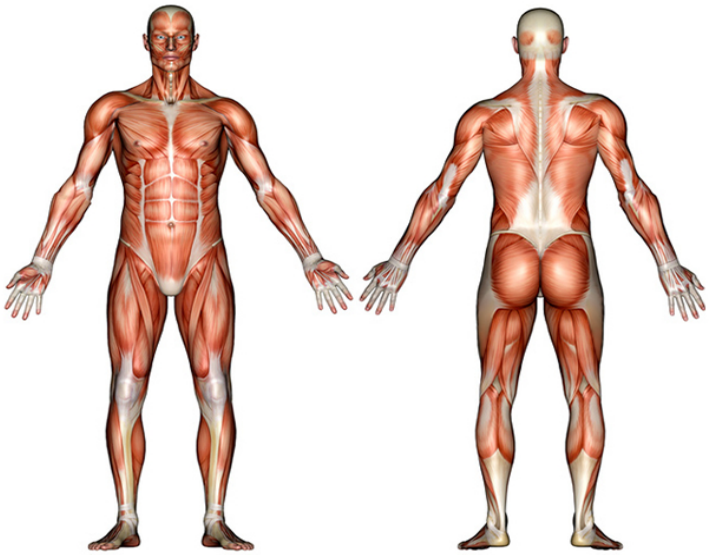
___ Yes ___ No

If *yes*, please indicate the date _____ Facility: _____

Name of Physician who performed the transplant: _____

Pain Assessment

Please mark the area(s) with an (x) on the pictures below where you are experiencing pain.



On a scale from 1-10, how bad is your pain?

According to the scale above, what is your current pain level? _____

According to the scale above, what is a tolerable level of pain? _____

What best describes the pain you are having? _____

Medication List

Pharmacy

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

Allergies: *please list food and drug allergies*

Food/Drug name	Reaction

Vitamins, Herbals and Nutritional Supplements

Name	Dose	How many do you take?

Medication List Continued

Medications: *please list all medications you are currently taking*

Name	Date Started	Dosage	Ordering Physician	How many a day do you take?

Financial Policy

To our patients,

Thank you for choosing our practice! We are looking forward to getting to know you. To prevent any misunderstandings concerning the responsibility for payment for any medical services rendered to our patients, please read the following:

The patient and/or guarantor are responsible for the payment for services provided by Antietam Oncology and Hematology Group at the time of service. The only exception to this is if Antietam Oncology and Hematology Group has contracted with your insurance company and will accept insurance payments in full after all deductibles, coinsurances and/or copayments have been paid. Any copayments not paid at the time of service rendered, will be subjected to a $10 late fee in addition to the copayment fee. All services performed in our office and at the hospital will be submitted to your insurance, unless we have prior notification of non-covered services. All copayments, deductibles and coinsurances are the patient responsibility.

If the patient's insurance requires a referral for services, it is solely the patient's responsibility to obtain the referral from your primary care physician prior to you visit. It is the patient's responsibility to keep track of referrals and to ensure expiration does not occur. If a referral is NOT presented at time of service, the patient has the option to reschedule or to pay the appointment fee in full.

If the patient misses an appointment, and does not call to cancel, the patient will be charged a $20 no show fee. As a courtesy, the first fee can be voided, any fees afterward will not be voided unless the patient is hospitalized or upon the providers request.

Our office accepts ***Visa***, ***Mastercard*** and ***Discover*** as well as cash and checks. All balances are due within 30 days, unless prior arrangements have been made with the Billing Department. I understand that any balance over 30 days will be assessed a 1.5% interest fee. All payment plans are expected to be paid in a three-month time span. If the patients account is assigned to the collection agency, *Valley Credit Service*, the patient will pay the collection fees of 25%, court costs, and attorney fees.

Returned checks will have a fee of $40 and applicable bank fees, upon receipt of a returned check, the patient will be responsible for payments made by cash only.

A minimum of $20 will be charged for any forms and/or copies of medical records. Additional charges may apply for medical records requiring more than 30 pages. This is not billable to the insurance company or account. Fees are expected before copies of records are faxed or given to the patient.

_____ _____

Signature of Patient or Legal Representative Date

Physicians and Referral Information

Referral Information

Primary Care Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Surgeon

Name: _____

Address: _____

Phone: _____ Fax: _____

Medical Record Release Information

As our patient, we may need to communicate with you when you are not in the office. To maintain your privacy, please indicate your preferred method for us to communicate confidential medical information, such as test or lab results, to you and/or others involved in your care.

PLEASE INDICATE YOUR COMMUNICATION PREFERANCES BELOW:

Method	Yes	No	Area Code, Extension, or E-mail
Home telephone			
Answering Machine			
Work Phone			
Cell phone			
E-mail address			
Other			

Without *specific permission*, we will **not** release any medical information to anyone other than you. In some cases, if you may wish any other person to have access to your medical information, please make us aware of their names, and relationship to you.

[] **Do not** release medical information to anyone other than myself

[] **I give permission** to release medical information to the individuals below

Name	Relationship	Phone Number

_____ _____

Signature of Patient or Legal Representative Date

Consent to Use or Disclosure of Protected Healthy Information for Payment, Treatments and Health Care Operations

By signing below, you hereby consent for Antietam Oncology and Hematology Group to use or disclose information about yourself that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You have the right to request that Antietam Oncology and Hematology Group restrict how Privacy Practice for Protected Health Information is used or disclosed to carry out treatment, payment or health care operations. The practice is not required to agree to requested restrictions; however, if the practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have acted in reliance on your authorization (as determined by our Privacy Officer). By signing below, you may recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

I acknowledge that I have provided Antietam Oncology and Hematology Group's Notice of Privacy Practices for protected health information (PHI).

_____ _____

Signature of Patient or Legal Representative Date

Insurance and Authorization for Treatment

Insurance

Primary Insurance _____

Policy Number _____

Policy Holder Name _____ DOB _____

Relationship to Policy Holder _____

Secondary Insurance _____

Policy Number _____

Policy Holder Name _____ DOB _____

Relationship to Policy Holder _____

Who is financially responsible for this account? _____

Financial Agreement and Authorization for Treatment

By this document, I do hereby request and authorize Antietam Oncology and Hematology Group, and its medical practice, providers, nurses, and any other qualified personnel to perform evaluation, treatment services and any procedures as may be necessary in accordance with the judgement of the attending medical provider. I acknowledge that no guarantee can be made by anyone concerning results of treatments, examinations or procedures. I authorize treatment and agree to pay all fees and charges for such treatment. I authorize the release of any pertinent information to my insurance company. I authorize all payment of insurance benefits be made on my behalf to Antietam Oncology and Hematology Group.

_____ _____

Signature of Patient or Legal Representative Date