CANCER CARE OF WESTERN NEW YORK
Patient Information
Page 1

A. PATIENT INFORMATION:

Name ______________________________ Primary Physician ______________________________
(Last) (First) (M.I.)
OB/GYN Physician ______________________________

Nickname/preferred first name______________________________

Address ______________________________
Street City Zip
Birth date __________ SS #: ______________ Home Phone____________ Work phone ____________

Cell: ____________ E-mail address: ______________________ Student_____ Full Time/Part time

Sex: M F Marital Status: S M W D Retirement Date __________ Retired from ______________________

Employer ______________________________ Occupation ______________________________

Spouse's name ______________________________ Birth date __________

Employer ______________________________ Occupation ______________________________

Pharmacy Name/Location ______________________________

Emergency Contact ______________ Address ______________________ Phone ____________

Relationship to patient: ______________________________

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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 ____________

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

____ Internet ____ Talking Phone Book ____ Bell Atlantic ____ Other (please specify) ______________

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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 __________

CANCER CARE OF WESTERN NEW YORK
Medical History
Page 2

PATIENT NAME:____ 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.

____

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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

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

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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

CANCER CARE OF WESTERN NEW YORK
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
    If yes, please specify: ____________________

11. Do you have an automatic defibrillator? YES NO

12. Lung problems; asthma, emphysema, bronchitis, pneumonia, or exposure to tuberculosis? YES NO
    If yes, please specify: ____________________

13. Do you have sleep apnea? YES NO
    If yes, do you use a C-PAP machine? YES NO

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

15. Is there a family history of:

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

16. Do you have children? ____ ____ How many? _________

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

18. Is there any chance you may be pregnant? YES NO

19. Are you nursing at this time? YES NO

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

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CANCER CARE OF WESTERN NEW YORK
Medical History

PATIENT NAME:____

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 WNYUA, 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 (PHI) to a third party by Western New York Urology Associates for purposes of treatment, payment, and/or health care operations.

____ ____________________
Required Signature of Patient and/or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge receipt of Western New York Urology Associates' Notice of Privacy Practices available to me.

____ ____________________
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 Western New York Urology Associates, 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 Western New York Urology Associates' policy and New York State Law.

____ ____________________
Required Signature of Patient and/or Responsible Party Date