Mid-Illinois Hematology & Oncology Associates, Ltd.

Patient Intake Form

Name: _____
First Middle Initial Last Suffix

SALUTATION or Name you wish to be called: _____

SEX: Male Female Date of Birth: _____

Social Security Number: _____

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

RACE: American Indian Alaskan Native Asian Black or African American Native Hawaiian

Other Pacific Islander White Other

Address (primary): _____

_____

(circle one) Is this address your: Home, Apt, Nursing Home or Other _____

Any other address you would like to have on file other than home: _____

_____

PHONE NUMBERS: Home: _____

Mobile (Cell): _____

Work: _____

Other: _____

(circle one) Which number would you like to be your primary contact number for reminders (NOTIFICATION PREFERENCE)? Home Mobile (Cell) Work Other

E-MAIL ADDRESS (necessary for CareSpace Portal, Patient Portal): _____

EMPLOYER: _____

Employment Status: _____ Full time _____ Part time _____ Retired _____Unemployed _____Student

PREFERRED LANGUAGE: _____

Relationship status: _____Single _____ Married _____ Partnered _____ Divorced _____ Widowed

Spouse Name and Phone Number: _____

Contact Person if other than spouse & contact information **& RELATIONSHIP TO PATIENT**:

_____

Emergency Contact (if other than spouse or other contact person):

_____

Do you have any ADVANCED DIRECTIVES in place? **If so, please provide a copy to the staff.**

Living Will YES or NO

Durable Power of Attorney YES or NO

Do Not Resuscitate YES or NO

** If not, are you interested in learning more? YES or NO

Insurance Information: (We will take a copy of your insurance cards but need the following information as well.)

RESPONSIBLE PARTY (Which member of your family carriers the insurance plan): Self or Other

IF OTHER, THEIR NAME: _____

IF OTHER, LIST RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY'S SS#: _____ & DATE OF BIRTH: _____

RESPONSIBLE PARTY'S EMPLOYER: _____

Any Health Care Providers (MD'S, NP'S or PA'S) that you see outside of this clinic and their specialty and address. Use end of this packet if needed.

Primary Care: _____

Referring: _____

Surgeon: _____

Obstetrician/Gynecologist: _____

Other specialists i.e. Dermatologist, Rheumatologists, Gastroenterologist:

_____

_____

_____

Any other medical problems that you have other than what you see **our** doctors for:

_____

_____

_____

_____

Have you ever had any surgery? If so, what and approx. when?

Type	Reason	Year	MD	Location

When was your last colonoscopy (lower GI scope)? _____

When was your last EGD (upper GI scope)? _____

When was your last mammogram? _____

When was your last bone density? _____

When was your last pap smear? _____

When was your last prostate exam and/or PSA? _____

Alcohol use: _____ Never _____ Socially _____ Stopped use _____ year

_____ Currently uses ___ Drinks per day ___ Drinks per week ___ Drinks per month ___ Drinks per year

Illicit Drug use: _____ Never _____ History of _____ _____ Currently using _____

Do you currently use tobacco products? YES or NO If so, what form of tobacco? _____

If yes, would you like information to stop using tobacco products? YES or NO

Have you ever used tobacco products? YES or NO

If yes, how long ago did you quit? _____

Have you ever had a blood transfusion? YES or NO

If yes, did you ever have a reaction to blood products? YES or NO

Does your religion prohibit you from taking blood products? YES or NO

Family Medical History (do any blood relatives have any medical problems that relate to the condition you are being seen by our providers for, such as hereditary blood disorders or cancer history (include relationship and age of onset):

_____

_____

PREFERRED PHARMACY with street address: _____

_____

Mail Order Pharmacy: _____

_____

List of ALL food and drug allergies that you have and type of reaction you have to them.

_____

_____

_____

Are you allergic to Latex? _____ YES or _____ NO

Please list ALL of your current medications. Please include the name, dose and how many times a day you take them. Please include all vitamins and supplements and any over-the-counter medications also. You may use the back of this page if you need to.

You will be asked to provide a written list of all medications at every visit.

Medication Name:	Strength:	How you take it:	Who prescribed it:
Example: Vitamin D	1000mg	1 time a day	Dr. John Doe

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I give consent to Mid-Illinois Hematology & Oncology Associates, Ltd. to use my private health information for treatment, payment, and healthcare operations.

I hereby authorize the release of information necessary to file a claim with my insurance company(s) and assign benefits otherwise payable to me, to the provider listed on the claim.

Although I have requested the doctor to bill my insurance company on my behalf, I understand that it is my responsibility to make sure the bill is paid in a reasonable amount of time. If for any reason any portion of the bill is not paid by insurance, I agree to make arrangements for prompt payment of the balance.

A copy of this signature is as valid as the original.

Signed: _____ Date: _____