PATIENT REGISTRATION
Dr. Mohtaseb Cancer Center and Blood Disorders

PATIENT INFORMATION		
Gender:	Marital Status:	Date of Birth: Age:
Last Name:		Social Security #:
First Name: Middle Initial:		Home Phone:
Address:		Cell Phone:
City, State, Zip:		Work Phone:
Employer:		Email address:
COORDINATION OF CARE INFORMATION		**EMERGENCY CONTACT INFORMATION**
Primary Care Provider:		**Name:**
Phone:		Relationship:
Preferred Lab:		Contact Phone:
Preferred Pharmacy:		**Name:**
		Relationship:
		Contact Phone:

INSURANCE INFORMATION		
Primary Insurance:		Insured Policy ID:
Second Insurance:		Insured Policy ID:
Third Insurance:		Insured Policy ID:

ADVANCE DIRECTIVE		
Do you have a Living Will?	**Yes / No**	Are you interested in more information? **Yes / No**
Do you have a Durable Power of Attorney?	**Yes / No**	Are you interested in more information? **Yes / No**
Do you have a DNR?	**Yes / No**	Are you interested in more information? **Yes / No**
(Do not resuscitate)		

OPTIONAL INFORMATION

How would you prefer to be contacted: [] Letter [] Email [] Phone [] Phone – no voicemail [] No reminders

How did you hear about our office? [] Radio [] Newspaper article/ad [] Medical provider [] Friend/Family [] Other

Race: America Indian, Asian, Black, Caucasian, Hispanic, Native Hawaiian, Other Pacific Islander, Other:

Ethnicity: Hispanic / Not Hispanic

Preferred Language: English, Spanish, French, Italian, Japanese, Russian, Other:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize this office to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges., I hereby authorize this practice to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. If at any time it becomes necessary to assign your outstanding balance due to an outside collection agency or attorney for collection of monies owe to this practice, you the patient/guarantor agree to, in addition to the principal balance owed, pay all related collection and/or legal costs and fees. This authorization shall continue and be in full force and effect until revoked in writing by me. I acknowledge receipt of the *NOTICE OF PRIVACY PRACTICE*

X_____ **Date:**_____

Signature

Dr. Mohtaseb Cancer Center and Blood Disoder (HOANJ, LLC)
Hamdy Mohtaseb MD, FACP

MY HISTORY

Name:_____ Date of birth: _____

Primary care provider name: _____

Referring provider name: _____

Reason for referral: _____

Chief complaint (primary reason for today's visit):

_____

_____

_____

MY MEDICAL PROFILE

MEDICAL CONDITIONS: (For example: high blood pressure, heart trouble, diabetes, depression, breathing problems, other)

Condition	Year Diagnosed	How Is it Treated

SURGERIES

Type of Surgery	Date	Hospital	Reason for Surgery

MY HISTORY

Name:_____ Date of birth: _____

SOCIAL HISTORY

Tobacco Use

Please check one

_ I have never smoked

_ I have smoked, but rarely

When was the last time?_____

_ I have quit smoking. Quit Date:_____

How many packs/day?_____ How many yrs?_____

_ I currently smoke _____pack(s)/day.

How many yrs._____

Other Tobacco: _ pipe _ cigar _ snuff _ chew

Are you interested in quitting? _ Y _ N

Alcohol Use

Do you drink alcohol? _ Y _ N

_ never _ occasionally _ regularly

Average # drinks/week? 5 oz. wine_____

12 oz. beer_____ 1.5 oz. hard liquor_____

Is alcohol use a concern for you or others? _ Y _ N

Drug Use

Do you use recreational drugs? _ Y _ N

Type of drug:_____

Have you ever used needles? _ Y _ N

Marital Status: _ single _ married _ separated _ divorced _ widow

Children: _ Y _ N If yes, how many: _____

Current occupation: _____

Secondary occupation: _____

_ Retired _ Full time student _ Disabled _ Never

Former occupation: _____

Occupational exposure (asbestos, benzenes, other chemicals, etc):

_____

MY HISTORY

Name:_____ Date of birth: _____

FAMILY HISTORY

	Mother	Father	Sister	Brother	Daughter	Son	Other (list)
Alive?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	
Anemia							
Bleeding disorders							
Blood count disorders							
Breast cancer							
Cancer							
Clotting disorder							
Colon cancer							
Diabetes							
Heart disease							
Hypertension							
Kidney disease							
Leukemia							
Lung cancer							
Lymphoma							
Melanoma							
Multiple myeloma							
Ovarian cancer							
Sarcoma							
Other (specify)							

MEDICATION I TAKE:

Information the doctor will want to know for each medication:

Why are you taking it?

How long have you been taking it?

What is the dosage?

How many times a day do you take the medication? (If you are not sure, bring the medication with you.)

Medication	Dose	Number of Times Taken Per Day	Date Started	Prescribed By

MY HISTORY

Name:_____ Date of birth: _____

OTHER MEDICATION I TAKE:

Remember to include on your list any over the counter (OTC) medicine you take (vitamins, herbs, pain relievers, supplements, etc.).

Other Medication	Dose	Number of Times Taken Per Day	Date Started

MY CANCER DIAGNOSIS

Date of Surgery or Biopsy	
Doctor	
Place Procedure Was Performed	
Surgery That Was Performed	
Results of My Surgery	
Primary Cancer Type	
Type of Tumor (Histological Type)	
Stage of Disease	
Any Problems Since My Surgery	

MY HISTORY

Name:_____ Date of birth: _____

ALLERGIES: (For example: medications, food, and/or other substances)

Allergy	Allergic Reaction (What symptoms develop?)

Any additional information you would like to share with your doctor:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The questions on this form have been answered to the best of my ability.

_____

Patient Signature: Date:

DR. MOHTASEB CANCER
CENTER & BLOOD DISORDERS

HIPAA Contact

In order to protect the privacy and confidentiality of your protected health information Dr. Mohtaseb Cancer Center & Blood Disorders staff members are requesting your permission to provide information to individuals other than yourself.

I agree/disagree that information directly related to my healthcare and billing can be released to family members, close personal friends or any other person(s) that are identified below.

I agree/disagree to be contacted by telephone for appointment confirmations, follow up regarding treatment or test results, in an emergency at work, and that you may leave a message on my voicemail.

Please identify individuals that you agree to allow Dr. Mohtaseb Cancer Center & Blood Disorders staff members to communicate healthcare and billing information to.

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

Name/Relation:_____ Phone:_____

_____

Signature of patient or legally authorized individual Date

_____

Print name of patient or legally authorized individual

_____

Relationship to patient, if signed by anyone other than the patient

DR. MOHTASEB CANCER
CENTER & BLOOD DISORDERS

Pharmacy Update

PATIENT INFORMATION			
Last Name:		First Name:	
Date of Birth:		Social Security #:	
PHARMACY INFORMATION			
Pharmacy		Phone number:	
Pharmacy		Phone number:	
Are you interested in Dr. Mohtaseb dispensing your prescriptions		YES NO	
PHARMACY INSURANCE			
Insurer Name:		ID:	
Rx Bin:		Rx Group:	
Rx PCN:			
Provide a copy of your pharmacy insurance card			

X_____ Date:_____
Signature