PROGRESSIVE ONCOLOGY & HEMATOLOGY CENTER

**FINANCIAL POLICY**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

REFERRRALS: Some managed care plans require written authorization forms from you primary care physician for each visit to Progressive Oncology & Hematology Center. It is the PATIENTS responsibility to make sure that a valid authorization form is obtained BEFORE each visit. THESE FORMS CAN NOT BE ISSUED RETROACTIVIELY.

1. Insurance is a contract between you and your insurance company. For the most part, we are not a party to this contract. We will inform you if we are a party to the contract, and will handle your claims according tour agreement with the insurance company. We file insurance claims as courtesy to our patients. We will not become involved in a dispute between you and your insurance company regarding deductible, copayments, covered charges, secondary insurance, “usual & customary charges,” etc. other than the to supply information as necessary. You are responsible at the timely payment of your account.
2. COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. If it becomes necessary to send you a bill for a copayment, there will be a $15.00 processing fee. If you have any questions regarding your office visit copayment, please contact your insurance company.
3. RETURNED CHECKS will be charged *a $25.00* processing fee.
4. *If you do not have insurance, an initial payment of $75.00 is due at time of service unless prior arrangements have been made.* For minor patients, the adult accompanying a minor (even in the care of a divorce) will be responsible for payment at the time services are rendered. We will not bill a different party.

*WE ACCEPT CASH, CHECKS, CREDIT CARDS AND MONEY ORDERS*

(Visa, MasterCard, Discover and American Express)

We would like to thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I authorize the release of any medial information necessary to process my insurance, or to another physician or medical facility if appropriate to expedite my medical care. I allow fax transmittal of my medical records, if necessary. I request payment of authorized Medicare/Insurance benefits be made to Progressive Oncology &b Hematology Center on my behalf, for any services furnished to me by them. I authorize any holder of medial information about me to release to the Health Care Financing Administration and its agents, or other insurance agencies, any information needed to determine benefits payable for related services.

I understand that I am financially responsible for all charges whether or NOT paid by insurance. If full payment is not made with regard to bills for services rendered, I agree to pay all necessary and reasonable costs of collections beginning at 27% of account balance. Including, but not limited to Attorney’s or collection agency for collection, and/or court costs. I agree to this provision.

I agree to accept all Financial Responsibility for services rendered.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian

Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Progressive Oncology & Hematology Center

**CLEAN CLAIM GUIDELINES**

I understand that by providing Progressive Oncology & Hematology Center complete and accurate information as requested, I am complying with the “Clean Claim Guidelines”. Clean Claim Guidelines state that I must provide my name, date of birth, social security number and complete address to the provider of service in order for the provider to bill my insurance company. If any information is refused or omitted by me, I understand that I am liable for payment for the services provided.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient, Guardian, or Guarantor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Guardian, or Guarantor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Progressive Oncology & Hematology Center

**PATIENT RECORDS OF DISCLOSURE**

In general, the HIPPA privacy rule gives the individual the right to request a restriction on uses and disclosures

of their protected health information (PHI). The individual is also provided the right to request confidential

communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

I wish to be contacted in the following manner (check all that apply)

[ ] Home Telephone [ ] Cell Phone

[ ] OK to leave message with detailed information [ ] OK to leave message with detailed information

[ ] Leave message with call back number only [ ] Leave message with call back number only

[ ] Work Telephone [ ] Written Communication

[ ] OK to leave message with detailed information [ ] OK to mail to my home address

[ ] Leave message with call back number only [ ] OK to mail to my work/office

[ ] Other [ ] OK to fax to this number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record.

*Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.*

He

|  |  |  |  |
| --- | --- | --- | --- |
| Date | To whom we can release information | Relationship | Phone Number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Progressive Oncology and Hematology Center**

Mouhamad Bazzi, MD

2405 Whittier Dr. Suite 100 Frederick, MD 21702

Phone: 301-682-2988 Fax: 301-682-2989

**MEDICAL RECORD RELEASE**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize you to release all my records, specimens and lab results to:

**Progressive Oncology and Hematology Center**

2405 Whittier Dr. Suite 100 Frederick, MD 21702

**PLEASE FAX ALL MEDICAL INFORMATION CHECKED BELOW TO:**

**Fax: 301-682-2989**

( ) RECENT History & Physical or Physicians notes

( ) ALL Operative/Procedure notes & Discharge summary

( ) RECENT Progress notes

( ) ALL CT scan, MRI, Mammogram, Ultrasound and X-Ray reports

( ) ALL Pathology reports

( ) ALL lab work to include CBC, Tumor Markers, etc.

( ) ALL chemotherapy/Radiation records

( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is valid from date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

DO YOU HAVE ANY SIGNIFICANT? (CHECK ONE OR DESCRIBE)

GENERAL: [ ] Weight loss/gain [ ] Fever [ ] Night Sweats

[ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EYES: [ ] Change in Vision

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EARS: [ ] Decrease hearing [ ] Ear Pain

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOSE: [ ] Sinus Problems [ ] Allergies

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THROAT: [ ] Frequent Sore Throats [ ] Persistant Hoarseness

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NECK: [ ] Frequent Neck Pain [ ] Arm Numbness, Tingling [ ] Thyroid Problems

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BACK: [ ] Frequent Back Pain [ ] Leg Pain, Numbness

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPIRATORY: [ ] Chronic Cough [ ] Shortness of Breath [ ] Wheezing

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARDIOVASCULAR: [ ] Exertional Chest Pain [ ] Palpitations [ ] Swelling of Legs

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GASTROENTEROLOGIC: [ ] Nausea/Vomiting [ ] Diarrhea [ ] Constipation [ ] Heartburn

[ ] Blood or Pain w/BM [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENITOURINARY: [ ] Urinary Problems [ ] Menstrual Problems [ ] Sexual Problems

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEUROLOGIC: [ ] Severe Headaches [ ] Dizzy Spells [ ] Seizures

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MUSCULOSKELETAL: [ ] Unusual Joint pains [ ] Unusual Muscle Pains

[ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DERMATOLOGIC: [ ] Skin Lesions [ ] Rashes

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEMATOLOGIC: [ ] History of Anemia [ ] Clotting Disorder [ ] Sickle Cell

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENDOCRINOLOGIC: [ ] Unusual Thirst [ ] Cold or Heat Intolerance [ ] Discharge from Breast

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PYCHOLOGIC: [ ] Depression [ [ Anxiety [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

**Living Deceased Age Illnesses**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Maternal Grandmother** |  |  |  |  |
| **Maternal Grandfather** |  |  |  |  |
| **Paternal Grandmother** |  |  |  |  |
| **Paternal Grandfather** |  |  |  |  |
| **Mother** |  |  |  |  |
| **Father** |  |  |  |  |
| **Siblings** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Children** |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Personal History

Childhood Illnesses Allergies [ ] YES [ ] NO

Measles [ ] YES [ ] NO Medications [ ] YES [ ] NO

Mumps [ ] YES [ ] NO If so, specify drugs:

Chicken Pox [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Food Allergies [ ] YES [ ] NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Animal Allergies [ ] YES [ ] NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adult Illnesses Injuries [ ] YES [ ] NO

Diabetes [ ] YES [ ] NO Have you had any broken bones or

High Blood Pressure [ ] YES [ ] NO significant accidents: [ ] YES [ ] NO

Heart Problems [ ] YES [ ] NO Please Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respiratory Problems [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Illness [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other [ ] YES [ ] NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgery Weight

Tonsillectomy [ ] YES [ ] NO Now \_\_\_\_\_\_\_\_\_ One year ago \_\_\_\_\_\_\_\_\_

Appendectomy [ ] YES [ ] NO Maximum \_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_

Hysterectomy [ ] YES [ ] NO

Including Ovaries [ ] YES [ ] NO Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hernia Surgery [ ] YES [ ] NO

Gall Bladder Surgery [ ] YES [ ] NO

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations**  **Medications**

Pneumonia [ ] YES [ ] NO Please bring a list all medications, vitamins,

When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ supplements, and hormones. You may

Tetanus: [ ] YES [ ] NO bring your medication bottles if this also if

When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ this is easier.

Hepatitis B [ ] YES [ ] NO

When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu Vaccine [ ] YES [ ] NO

When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others [ ] YES [ ] NO

Please Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been tested for:

Tuberculosis [ ] YES [ ] NO

If so, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits** **Women Only**

Menstrual History

Do you exercise regularly [ ] YES [ ] NO

How often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at onset \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke [ ] YES [ ] NO Regular [ ] YES [ ] NO

How much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cycle: Every \_\_\_\_\_\_\_days

How many years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual Duration \_\_\_\_\_\_\_\_\_\_\_\_\_days

Did you ever smoke [ ] YES [ ] NO Heavy Medium Light

How many years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain or Cramps [ ] YES [ ] NO

Do you chew tobacco/snuff [ ] YES [ ] NO First Day of Last Cycle \_\_\_\_\_\_\_\_\_\_\_\_\_

How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Pap Smear \_\_\_\_\_\_\_\_\_\_\_\_

Ever take Estrogen [ ] YES [ ] NO

Regular Self Breast Exams [ ] YES [ ] NO How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink Alcohol [ ] YES [ ] NO Have regular Mammos[ ] YES [ ] NO

Regular Moderate Daily Never

Date of last Mammogram \_\_\_\_\_\_\_\_\_\_\_

How many drinks in a week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been treated for **Pregnancies**

Chemical Dependency [ ] YES [ ] NO

How many \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your diet well balanced [ ] YES [ ] NO

Fat Intake: Light Moderate Heavy How many live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many miscarriages \_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Intake Light Moderate Heavy

Complications [ ] YES [ ] NO

How much coffee/tea in a day \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much cola in a day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first term pregnancy \_\_\_\_\_\_\_\_\_\_

**Progressive Oncology and Hematology Center**

Dr. Mouhamad Bazzi, MD

2405 Whittier Dr. Suite 100 Frederick, MD 21702

Phone: 301-682-2988 Fax: 301-682-2989

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the notice of Privacy practices and I have been

provided an opportunity to review it.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Progressive Oncology and Hematology Center**

2405 Whittier Dr. Suite 100 Frederick, MD 21702

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_

Last First MI

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male [ ] Female [ ] Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Case of Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address (for Patient Portal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mothers Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an Advanced Directive [ ] YES [ ] NO Do you have a Living Will [ ] YES [ ] NO

**INSURANCE INFORMATION**

Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s SSN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is this policy thru an employer? [ ] YES [ ] NO

**Primary Insurance** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy or ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Benefits/Eligibility Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy or ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Benefits/Eligibility Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REMINDER: PLEASE CONTACT INSURANCE TO VERIFY COVERAGE & IN / OUT OF NETWORK**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby certify that the above information is accurate. I agree to notify you of any change in insurance, address or phone number.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION LOG**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **(STAFF USE ONLY)** | |  |  | |
|  |  | |  |  | |
| **Medication** | **dose** | **frequency** |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |
|  |  |  |  | |  | |  |  |