

Appointment Date: \_\_\_\_\_ Acct #: \_\_\_\_\_ (office use only)

Name: \_\_\_\_\_ **Social Security#:** \_\_\_\_\_

Address: \_\_\_\_\_ **Drivers License Number:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: M F **Birthdate:** \_\_\_\_\_ Age: \_\_\_\_\_ Single Married Widowed Separated Divorced

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Pharmacy Name & Phone: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Referring Doctor: \_\_\_\_\_

Name of Spouse or Resp. Party: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address (if different than above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact Name & Phone: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insurance Co. Name: \_\_\_\_\_

Phone: \_\_\_\_\_ **DOES YOUR INSURANCE REQUIRE ANY PRE AUTHORIZATION?**

Subscriber Name (if other than patient) \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

ID#: \_\_\_\_\_ Group/Plan#: \_\_\_\_\_

**SECONDARY or SUPPLEMENTAL INSURANCE INFORMATION**

Insurance Co. Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Subscriber Name (if other than patient) \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

ID#: \_\_\_\_\_ Group/Plan#: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I hereby authorize payment directly to the Physician for all medical benefits, if any, otherwise payable to me for services rendered, realizing I am responsible to pay for non covered services. I authorize the Physician to release any information in the course of my treatment necessary to process insurance claims.

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



## New Patient Information Form

Name

Date

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Birthday

Age

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1 ) Who is your referring physician? \_\_\_\_\_

2 ) What other practitioners are you receiving care from currently? \_\_\_\_\_

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3 ) What is the reason for your referral? How long have you had/known about this issue? \_\_\_\_\_

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4 ) What are your goals/health concerns for this visit? \_\_\_\_\_

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5 ) Past Medical History: Please check Yes or No for any illness you have had and describe below.

	Yes	No
Anemia / Low Blood Counts		
Arthritis		
Asthma / Bronchitis / Emphysema		
Bleeding / Bruising		
Blood Disorder		
Cancer (type)		
Depression / Emotional Problems		
Diabetes		
Drug / Alcohol Dependence		
Epilepsy / Seizures		
Hay Fever / Sinus Problems		
Heart Problems		

	Yes	No
Hepatitis		
High Blood Pressure		
Immune Disorders		
Intestinal Problems		
Kidney Disease		
Liver Disease		
Lung Disease		
Skin Disease		
Stroke		
Stomach Ulcers		
Thyroid Disease		
Other (describe below)		

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6 ) Have you been hospitalized recently? When, where and for what reason? \_\_\_\_\_

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7 ) Please list all past surgeries and dates. \_\_\_\_\_

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10 ) SOCIAL HISTORY. Please tell us about your personal lifestyle and habits. It is OK if you choose not to answer these questions.

What is your current / prior occupation? \_\_\_\_\_ Are you retired? Yes No

Do you live alone? Yes No If no, whom do you live with? \_\_\_\_\_

Do you smoke or have you used tobacco products in the past? Yes No

If so, how many years / packs per day do/did you smoke? \_\_\_\_\_

When did you quit / are you interested in quitting? \_\_\_\_\_ Yes No

Do you drink alcohol? Yes No If so, how many drinks did you have last week? \_\_\_\_\_

Have you ever been to an AA (alcoholics anonymous) meeting? Yes No

Do you use / have taken any drugs including marijuana, cocaine, stimulants or sedatives?  
(List frequency and last use.)

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Have you ever been tested for HIV, Hepatitis, or any sexually transmitted disease?  
(List any results.)

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Have you ever received a blood transfusion or blood derived products?  
(List all dates.)

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Do you exercise? Yes No If so, how many times a week? \_\_\_\_\_  
If not, describe your typical daily activity level / hours spent out of bed.

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Are you on any special diet or have any nutritional concerns?  
If yes please describe

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Are you interested or have used any Complimentary and Alternative health strategies for any disease.  
(Please explain.)

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Do you have difficulty paying for medical care? Yes No

11 ) FAMILY HISTORY. Please describe any cancers or blood disorders in your family members.

	Type of cancer or blood disorder	Age
Mother		
Father		
Brothers		
Sisters		
Children		
Uncles		
Aunts		
Cousins		
Grandparents		

12 ) Review of Systems: Have you experienced any of the following in the past 3-6 months?

	Yes	No	Patient Comments	Provider Comments
Change in general health				
Recent weight changes				
Recurrent fevers, chills, or sweats				
Heat or cold intolerance				
Extreme fatigue				
Change in appetite				
Excess thirst or urination				
Difficulty sleeping				
Nervousness / Anxiety				
Difficulty sleeping				
Depression				
Delusions / Hallucinations				
Easy bruising				
Frequent or prolonged bleeding				
Enlarged lymph nodes				
Decreased resistance to infection				
Unusual rash / Skin problems				
Delayed healing				
Itching				
Change in hair or nails				
Headaches				
Numbness / Tingling sensation				
Weakness / Paralysis				
Convulsions / Seizures				
Confusion / Change in memory or concentration				
Black outs / Dizziness				
Change in hearing / Ringing in ears				
Recent nose bleeds				
Chronic sinus problems / Runny nose				
Allergy symptoms				
Voice changes				
Recurrent sore throat				
Difficulty swallowing				
Wear glasses or contact lenses				
Change in vision				
Pain or irritation in eye(s)				
Redness or discharge from eye(s)				
Breathing problems / Shortness of breath				
Chronic cough				
Coughing-up blood				

12 ) Review of Systems: ( continued )

	Yes	No	Patient Comments	Provider Comments
Chest pain or angina				
History of heart murmur				
Irregular heart rhythm / palpitations				
Swelling of feet, ankles, hands				
Recurrent urinary infections				
Hesitancy or dribbling of urine				
Blood in urine				
Pain during urination				
Urine leakage				
Prostate biopsy or surgery				
List date, procedure & last PSA blood test				
Kidney stones				
Severe heartburn				
Nausea or vomiting				
Vomiting blood				
Abdominal pain				
Constipation				
Frequent diarrhea				
Black or bloody stools				
Joint / Muscle stiffness, pain, weakness				
Neck pain / back pain				
Difficulty walking				

13 ) For Women Only: Please answer the following questions:

	Yes	No	Patient Comments	Provider Comments
Do you have a gynecologist?				
Have you ever had a mammogram?				
Where /when was your last mammogram?				
Have you ever had an abnormal mammogram?				
Have you ever had a breast biopsy or surgery? List date and result.				
Do you have a history of breast pain, lumps or swelling?				
Do you routinely practice self-breast exams?				
When was your last pap smear?				
Have you ever had an abnormal pap smear?				
Have you ever had a sexually transmitted disease?				
How old were you when you had your first menses?				
Do you still have menses?				
When was your last menses?				
Describe your menses- light, moderate, heavy?				
Are your menses painful or irregular?				
Have you ever had anemia or taken iron?				
List all pregnancies, deliveries, miscarriages and abortions.				
How old were you at the time of your first delivery?				
Did you have any complicated pregnancies? If yes, describe.				
Did you ever take oral contraceptives (birth control pills)? If so, list name and duration.				

13 ) For Women Only: ( continued )

	Yes	No	Patient Comments	Provider Comments
Did you ever take hormone replacement therapy or estrogen? If so, list name and duration.				
Have you had a hysterectomy (removal of uterus)? Have you had a oophorectomy (removal of ovaries)? If so, when?				
Do you suffer from hot flashes, vaginal dryness, irritability?				
Have you ever had a blood clot, stroke, or heart attack?				
Have you ever had a bone density study (Dexa Scan)? If so, when?				
Do you have a history of osteoporosis / osteopenia?				

14 ) Pain & Functional Status: As health care providers, we are concerned about your comfort.

Do you suffer from pain?      Yes      No      If yes, answer the questions in the box below:

Where is your pain? \_\_\_\_\_

What does your pain feel like? \_\_\_\_\_

Circle a number from 0-10 that best describes how much pain you are having now:

1	2	3	4	5	6	7	8	9	10
No Pain					Worst Pain Possible				

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Does the pain limit your activity or interfere with your sleep? If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Please list any medication(s) or other type(s) of treatment you use for pain relief: \_\_\_\_\_

\_\_\_\_\_

An Advance Health Care Directive is a document that provides instructions regarding your medical care in the event of serious medical problems. It also allows you to define who may make health care decisions for you if you are unable to make decisions for yourself. It has previously been called a "Living Will" or "Durable Power of Attorney for Health Care"

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|--|-----|----|
| Do you have an Advance Health Care Directive?  | Yes | No |
| If no, would you like information about Advance Directives?  | Yes | No |
| If you are older than age 65 or have any chronic medical condition(s) please answer the following: |     |    |
| Do you have any difficulty bathing or dressing yourself?   | Yes | No |
| Do you ever lose control over your urination or bowel movements?                                   | Yes | No |
| Have you had 3 or more falls in the past year?   | Yes | No |
| Have you experienced any change in your ability to do your usual activities?                       | Yes | No |
| Are you receiving any special help at home?  | Yes | No |

Signature \_\_\_\_\_

Date \_\_\_\_\_

## CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

**Date:** \_\_\_\_\_ **Re:** \_\_\_\_\_  
(Patient's Name)

I authorize **Orange Coast Oncology Hematology Medical Associates, Inc.** to use and disclose the health and medical information of above-referenced patient for the purposes of \*Treatment, \*\*Payment and \*\*\*Health Care Operations.

**\*Treatment** (includes activities performed by a health care provider, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

**\*\*Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

**\*\*\*Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Orange Coast Hematology Medical Associates, Inc.'s "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in the consent prior to signing the consent. Please verify that you have received a copy of our Notice by placing your initials here: \_\_\_\_\_.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that OCOH has already used or disclosed the information in reliance on this Consent.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Authorized by Law

\_\_\_\_\_  
Date

**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. Before starting medical services and treatment or at your first visit, we require all of your insurance information, including a current insurance ID card and any referral or authorization that may be required. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions regarding your insurance coverage prior to your visit, you are welcome to contact our Business Office at 949-723-5178.

**UNINSURED PATIENTS**

Payment is due in full at the time of service for all office visits, procedures and treatment unless other arrangements are made in advance with our Business Office. We accept cash, checks and major credit cards.

**INSURANCE\***

It is your responsibility to know the details of your health insurance plan. The patient is responsible for obtaining any required pre-authorization and/or referral for outside lab, diagnostic procedures and x-ray testing. If you are unsure as to where outside testing must be performed, please contact your health plan. Our office will not be held responsible for out of pocket expenses from utilizing the wrong provider or not obtaining pre-authorization. Payments for outstanding patient balances are due within 30 days of the statement date unless other arrangements have been made with our Business Office.

**PPO-POS INSURANCE**

We will bill your insurance plan. **ALL APPLICABLE CO-PAYMENTS ARE DUE AND WILL BE COLLECTED AT THE TIME OF YOUR VISIT.**

**MEDICARE**

Our physicians are participating providers with the Medicare program and accept "assignment." The 20% co-insurance is payable by the patient unless supplemental insurance coverage is provided. Please be advised Medicare does not cover self administered injections outside of our office.

**LAB TESTS AND OTHER CHARGES**

If your visit includes lab tests, x-rays/scans or biopsies, you will receive separate billing from the company performing the processing and evaluation of those tests; e.g., Hoag Hospital, Newport Imaging, Newport Diagnostics, Westcliff Labs, Impath Laboratories, etc. We will provide your insurance billing information to these facilities.

\*Insurance is a contract between you and your insurance company. We are a party to this contract in some cases. If we are a party to your insurance, we will handle claims according to our agreements with the insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, usual and customary charges, etc., other than to supply information as necessary. You are ultimately responsible for the timely payment of your account.

**I have read and understand the above information.**

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<b>Print Patient Name</b>	<b>Signature</b>	<b>Date</b>
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<b>Responsible Party Name</b>	<b>Signature</b>	<b>Date</b>
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