Patient Registration Form **|| New Patient || Update Information**

Last Name: _____ **First Name:** _____ **Middle:** _____

Title: O Mr. O Mrs. O Ms. O Dr. SEX: O **MALE** O **FEMALE**

Date of Birth: _____ **SSN#:** _____-_____-_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home #: _____ **Work #:** _____

Cell #: _____ **Email:** _____

Referring Doctor Name: _____ Phone #: _____

Referring Doctor Address: _____

Primary Care Doctor Name: _____ Phone #: _____

Primary Doctor Address: _____

Insurance Information:

Primary Carrier Name: _____ **Are you the insured?** O YES O NO

If **NO**, Insured/Subscriber Name: _____
Insured DOB: _____ Relationship to Insured? _____

Claims Authorization for Medicare and Other Health Insurance Plans:

INSURANCE: I hereby authorize Manhattan Hematology Oncology to furnish and all records, medical history, services rendered or treatment given to me or any dependant for purposes of review, investigation or evaluation of any claim submitted to my insurance carrier. I also authorize the insurance company to disclose to a hospital or healthcare service plan and/or self-insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entity, the authorization also permits disclosure to them for purposes of utilization review or audit. The authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurance carrier including a reasonable time thereafter, until it's final consummation. This authorization shall be binding upon me, my dependants, and our heirs, executors and administrators.

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to MHOA for any services furnished by MHOA to me. I authorize any holder of medical information about me to release to the HealthCare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I verify the accuracy of this information and authorize the release of information as provided above:

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION TO PAY: I request payment of this claim and, if the payor accepts assignment, authorize payment direct to MHOA for services rendered.

I am in agreement with the authorization to pay statement on this form:

SIGNATURE: _____ **DATE:** _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices for **Manhattan Hematology Oncology Associates, P.C.**

SIGNATURE: _____ **DATE:** _____

REASON FOR TODAY'S VISIT:

HISTORY & PHYSICAL:

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	YES	NO
1. Heart trouble?	O	O
2. High Blood Pressure?.....If YES, how long? _____	O	O
3. Lung disease, asthma, emphysema, bronchitis, pneumonia, etc.?	O	O
4. Diabetes?	O	O
5. Jaundice or hepatitis?	O	O
6. Abnormal/prolonged bleeding or clotting difficulties?	O	O
7. Have you ever been told you have anemia? ..... If YES, when? _____	O	O
8. Have you ever been told of a platelet abnormality?.....If YES, when? _____	O	O
9. Have you ever been told of a malignancy? .....If YES, when? _____ By what physician? _____		
10. Have you ever received chemotherapy or radiation treatment?	O	O
11. Have you been hospitalized recently? ..... If YES, name of hospital and dates of admission: _____	O	O
12. Are you being treated by any other physician? ..... If YES, physician's name, address and phone number: _____ _____ _____	O	O
13. Have you had any fractures?	O	O
14. Have you had any convulsions, been unconscious or blacked out?	O	O
15. Have you ever been dizzy, off balance or light-headed?	O	O
16. Are you pregnant?	O	O
17. Do you smoke cigarettes?	O	O
18. Do you drink alcohol frequently?	O	O
19. Are you currently taking any medications/drugs? ..... If YES, please list them or provide medication list: _____ _____ _____	O	O
20. Allergies to medication? ..... If YES, please indicate which medication: _____ _____ _____	O	O
21. Other allergies: FOOD, POLLEN, DUST, ETC.? .....If YES, please circle one?	O	O

22. Please list surgeries (if any): _____ _____

23. Last physical exam: DATE: _____

24. Please provide additional information: _____ _____

EMERGENCY CONTACT NAME: _____

Relationship: _____ Phone: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____ **DOB:** _____

Authorization for Use/Disclosure of Information:

I voluntarily authorize and direct my health care provider Alec S. Goldenberg, M.D. and Karen J. Haglof, M.D. of Manhattan Hematology Oncology Associates, P.C. to use or disclose my health information during the term of this authorization to the recipient that I have identified below.

Recipient:

Name of person or class of persons to whom my health care provider may disclose my health information to:

_____

Purpose: I understand that the specific purpose of this authorization is to **enable my doctor to release my health information as needed for claims processing, diagnostic testing or referring physicians.** **PLEASE INITIAL:** _____

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

O All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
O All of my health information described above except for the following:

_____

O Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation):

_____

Term: This Authorization will remain in effect until such time my care is transferred or until (Insert Date): _____

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my healthcare provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable Federal and State Law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the **Manhattan Hematology Oncology Associates, P.C. Privacy Officer** for answers to my questions about the privacy of my health information at **157 East 32nd Street New York, NY 10016, or by telephone at 212.689.6791.**

Patient Signature: _____ **Date:** _____

Signature of Witness of office staff member: _____

If individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/Representative: _____ **Date:** _____

Relationship to patient: _____

NOTE: THIS FORM CANNOT BE USED TO AUTHORIZE A RELEASE OF HIV-RELATED INFORMATION AS PROTECTED BY FEDERAL LAW

STAFF USE ONLY:

If patient REFUSES to sign AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION, please check below and initial:

O **Staff Initials:** _____

Manhattan
Hematology Oncology
Associates, p.c.

Patient Medications and Allergies

Patient Name: **Date of Birth:**

Have you seen any other physicians since your last visits? (Yes) (No)

1. Physician Name: _____
   Address: _____ Phone: _____
2. Physician Name: _____
   Address: _____ Phone: _____

Prescription Medications

Drug 1: _____ Drug 7: _____
Drug 2: _____ Drug 8: _____
Drug 3: _____ Drug 9: _____
Drug 4: _____ Drug 10: _____
Drug 5: _____ Drug 11: _____
Drug 6: _____ Drug 12: _____

Over-the-Counter Medications

Drug 1: _____
Drug 2: _____
Drug 3: _____
Drug 4: _____
Drug 5: _____

Vitamins

Drug 1: _____
Drug 2: _____
Drug 3: _____
Drug 4: _____
Drug 5: _____

Drug Allergies

1. _____
2. _____
3. _____
4. _____

Other Allergies

1. _____
2. _____
3. _____
4. _____