Prashant R. Patel, M.D. RPH
Alpana A. Desai, M.D.

STUART ONCOLOGY ASSOCIATES, P.A.

Marinely Cruz-Amy, M.D.
Guillermo Abesada-Terk, M.D.

** Please provide ALL information requested**

NEW PATIENT INFORMATION

Name_____SSN_____
Last First MI

Address_____City_____ST_____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____D.O.B. _____/___/_____

Emergency Contact_____
Name Phone Number Relationship

RACE American Indian ❑ Asian ❑ African American ❑ Caucasian ❑ Hawaiian Pacific ❑ Other ❑

ETHNICITY Hispanic ❑ Non Hispanic ❑ Prefer Not Answer ❑ Preferred Language_____

Are you currently in a Nursing home? _____Nursing home name_____

Do you have DNR? Yes/ No Do you have a living will? Yes/ No

Referring Physican_____ Which doctor are you seeing today?_____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME_____

ID#_____ Group Control #_____ Copayment_____

Address_____City_____ST_____Zip_____

Home Phone_____ Work Phone_____ Employer_____

Name of Insured as it appears on card_____Sex_____
Last First MI

Relation to patient_____ Card Holder SSN_____ Card Holder Birthdate_____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY NAME_____

ID#_____ Group Control #_____ Copayment_____

Address_____City_____ST_____Zip_____

Home Phone_____ Work Phone_____ Employer_____

Name of Insured as it appears on card_____Sex_____
Last First MI

Relation to patient_____ Card Holder SSN_____ Card Holder Birthdate_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Stuart Oncology Associates, PA all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for all insurance submissions.

Signature_____ Date_____

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New Patient Medical History Form

Patient Name_____ MRN# _____

Reason for Visit _____

_____

Medical History (Check the items that apply to you, currently or in the past)

- ❑ None
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Blood disorder
- ❑ Frequent infections
- ❑ HIV/AIDS
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Atrial fibrillation
- ❑ Congestive heart failure
- ❑ Heart attack-MI
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Heartburn/ Reflux
- ❑ Heart murmur
- ❑ Irregular heart beat
- ❑ Peripheral vascular disease
- ❑ Asthma
- ❑ Chromic lung (COPD)
- ❑ Pneumonia/Bronchitis
- ❑ TB (tuberculosis
- ❑ Sleep apnea
- ❑ Colon polyps
- ❑ Crohn's disease
- ❑ Diverticulitis
- ❑ Irritable bowel syndrome
- ❑ Ulcerative colitis
- ❑ Stomach ulcers
- ❑ GERD/Heartburn
- ❑ Hiatal Hernia
- ❑ Gallstones
- ❑ Cirrhosis of liver
- ❑ Hepatitis A/B/C
- ❑ Pancreatitis
- ❑ Kidney stones
- ❑ Kidney disease/failure
- ❑ Frequent urinary tract infections
- ❑ Enlarged prostate
- ❑ Lupus-autoimmune
- ❑ Reynaud's syndrome
- ❑ Rheumatoid arthritis
- ❑ Osteoarthritis
- ❑ Chronic back pain
- ❑ Osteoporosis
- ❑ Fracture
- ❑ Stroke
- ❑ Neuropathy
- ❑ Parkinson's disease
- ❑ Paralysis
- ❑ Seizures
- ❑ Migraines
- ❑ Shingles
- ❑ Glaucoma/ cataracts
- ❑ Hearing loss
- ❑ Cancer
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Anxiety
- ❑ Depression
- ❑ Drug use
- ❑ Problems with anesthesia
- ❑ Other _____
- ❑ Other _____

Details of Medical History _____

_____

Cancer History Type_____ Date diagnosed_____

Treatment Type_____ Date _____

Location of treatment_____Treating Physician _____

Past Surgical History (Please circle and date any of the surgeries and/or procedures that you have undergone)

Coronary Bypass	Date_____	Rotator Cuff Repair	Date_____
Angioplasty	Date_____	Cataract	Date_____
Pacemaker	Date_____	Gallbladder Surgery	Date_____
Cardiac Valve Surgery	Date_____	Hysterectomy	Date_____
Hemorrhoidectomy	Date_____	Prostatectomy	Date_____
Prostate Operation	Date_____	Appendectomy	Date_____
Hernia Repair	Date_____	Hip Replacement	Date_____
Tonsillectomy	Date_____	Lumpectomy	Date_____
Mastectomy	Date_____	Other	Date_____
Knee Replacement	Date_____	Other	Date_____

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New Patient Social History Form

Tobacco Use (Present And/Or Past)

❑ Never smoked ❑ Quit smoking when? ❑ How many years did you smoke? ____Year ❑ How many packs? ____ Day
❑ Currently smoke ❑ cigarettes ❑ pipe ❑ cigars How many packs? ____Day how many years? ____
❑ Chewing tobacco

Alcohol History (Present And/Or Past)

❑ Non Drinker ❑ Beer Number Of Bottles Per ____Day ____Week ____Month
❑ Wine Number Of Glasses Per ____Day____ Week____ Month
❑ Liquor Number Of Glasses Per ____Day____ Week____ Month

Are You ❑ Employed/Self ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled
(Former) Occupation_____

Name Of Employer_____ Work Phone (___) _____

Marital Status

❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Lives With Family ❑ Lives Alone
❑ Lives In Nursing Home ❑ Winter Resident ❑ Year Round Resident ❑ Other

Local address_____ City_____ ST_____ Zip:_____
Permanent Address (If different) _____ City_____ ST_____ Zip:_____
Children ❑ Yes ❑ No Number _____

Health Maintenance

Sigmoidoscopy/Colonoscopy ❑ Yes ❑ No Date _____
Findings_____

Last Mammogram Date_____ Last Bone Density Date_____
Last Pelvic Exam Date_____ Influenza (Flu) Shot Date_____
Pneumococcal Shot Date_____ Last Shingles Shot Date_____
Last EGD Date_____

Family Medical History indicate any family members with cancer, blood disease or other disease.

	Age	Disease	If Deceased, Cause Of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
Siblings	____	_____	_____
Siblings	____	_____	_____
Siblings	____	_____	_____
Siblings	____	_____	_____

In your opinion, are there any diseases that run in your family? ❑ Yes ❑ No
Please List _____

_____

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New Patient Medication Form

Name_____ Date_____

Date of Birth _____

Allergies List all medication allergies

Medication _____Reaction _____

Medication _____Reaction_____

Medication _____Reaction _____

❑ Iodine ❑ Latex ❑ Shellfish ❑ CT Scan Dye / IV Contrast ❑ Eggs ❑ Peanuts

Pharmacy

Pharmacy_____Ph#_____

Address _____City_____

List all medications (including non-prescription) that you are currently taking.

Medication	Dose	Frequency	Ordering Physician

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HIPAA Patient Consent Form

Our Notice Of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you if used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect and disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portablility And Accountability Act Of 1996 (Hippa).

The patient understands that:
I authorize Stuart Oncology Associates P.A. to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including;medical, psychiatric, laboratory studies, HIV testing and other medical data related to my care. I authorize any insurer or payor to make payment directly to Stuart Oncology Associates P.A.. A photocopy of this authorization shall be considered as effective and valid for the duration of this claim.

Protected health information may be disclosed or used for treatment, payment, or health care options.
The practice has a notice of privacy practices and that the patient has the opportunity to review this notice.
The practice reserves the right to change the notice of privacy practices.
The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
The patient may revoke this consent in writing at any time and all future disclosures will then cease.
The practice may condition receipt of treatment upon the execution of this consent.

Acknowledgement Of Notice Of Privacy Practices

My signature below verifies that I, _____, have received a copy
(Print Name)
of notice of privacy practices from Stuart Oncology Associates P.A.

Signature of Recipient_____ Date _____/_____/_____

PROTECTED HEALTH INFORMATION AUTHORIZATION (OPTIONAL)

Consent To Disclose Medical Information

Please check one of the following:

____ I give my permission to the employees of Stuart Oncology Associates P.A. to disclose my protected health information to me and the following family and friends

Name _____ Relation _____
Name _____ Relation _____
Name _____ Relation _____
Name _____ Relation _____
Name _____ Relation _____

_____ I request that all my protected health information be disclosed only to me and no other family or friends. I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one.

Patient's Signature _____ Date _____

Patient -Print Name _____

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Patient Financial Responsibility Form

Dear Patient,

Thank you for choosing Stuart Oncology Associates, P.A. as your health care provider. We are committed to providing you with quality health care. Occasionally patients have questions regarding patient and insurance responsibility for services they receive. We have developed a payment policy to help you understand your responsibility and that of your insurance carrier (if applicable). Please read the policy and sign in the space provided. A copy will be provided to you upon request. If you have questions, please let us know.

Insurance. Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your insurance plan for you, as long as you provide us with accurate information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

___1. The patient (or patient's guardian, power of attorney) is ultimately responsible for the payment of treatment and care.

___2. Patients are responsible for payment of copays, coinsurance, deductibles, and any non covered treatment and services not paid for by your insurance.

___3. If you fail to provide us with the correct insurance information in a timely manner you will be billed for all insured charges.

___4. Your insurance may need certain information directly from you. It is your responsibility to comply with their request.

___5. Stuart oncology will attempt to bill your insurance company twice in an effort to collect payment. In the event your insurance does not pay for billed services the balance will be your responsibility.

___6. HMO insurance companies require a referral, it is the patient's responsibility. To ensure that a current and valid referral is obtained.

___7. Missed appointments - there may be a 40.00 fee for appointments not cancelled more than 24 hours in advance. Patients who do not reschedule within 30 days or have a history of repeatedly not showing may be subject to dismissal for "non compliance."

___8. Financial Agreement- I understand that my insurance contract is between me and my insurance company. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being turned over to an outside collection agency. If this becomes necessary, I agree to pay all collection fees which include but are not limited to collection agency fees, court fees, attorney fees, and any other fees for the collection of my account balance. Further, I consent to Stuart Oncology Associates, P.A. inquiries into my credit history in conformity with legitimate business needs and applicable laws, rules, and regulations.

Signature _____ Date _____

Spouse/Guarantor _____ Date _____

Witness _____ Date _____

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MEDICAL RECORDS RELEASE

Date _____/____/_____

I hereby request that my medical records be sent to:

_____

Physician's Name

_____

Address City State Zip

_____

Patient's Name (Please Print)

_____

Patient's Signature

_____

(Patient's) Address City State Zip

Birthdate_____/_____/_____ **Lasy four digits of Socail Security #** ___ ___ ___ ___

Reason for Request of Records

_____

_____

Request Authorized by _____

(Physician's Signature)

How Records to be Sent

Pick up _____ Date____/_____/_____ Patient's Signature _____

(At Time Of Pick Up)

Fax # _____ Date____/_____/_____ Employee Signature _____

Mail _____ Date____/_____/_____ Employee Signature _____

501 S.E. Osceola Street • Suite 301 • Stuart, Florida 34994 • (772) 223-5955 • Fax (772) 223-5954