**Katy Office**
18400 Katy Freeway, Suite 320
Houston, TX 77094
P. 281.647.7766 • F. 281.647.7767

**West Houston Office**
12121 Richmond Ave, Suite 226
Houston TX 77082
P. 281.556.6622 • F. 281.647.7767

www.PremierOncology.com

## Patient Information

Patient Name (First, Middle Initial, Last): ______________________________

Mailing Address (include City, State, and zip): ______________________________

______________________________

Street Address (if different than mailing): ______________________________

______________________________

Home Phone: ____________________ Work Phone: ____________________

OK to Leave Message at Home: __________ OK to Leave Message at Work: __________

Cell Phone (Mandatory):______________________________

Social Security Number: ____________________

Date of Birth: __________ Marital Status: ____________________

Email Address: ______________________________

Ethnicity : ____________________ Language:____________________

Primary Physician (Mandatory): ______________________________

Primary Physician Phone Number: ______________________________

Referred by: ______________________________

Employer Name: ____________________ Work Phone: ____________________

Address: ______________________________

______________________________

Emergency Contact Name: ____________________Relationship:__________

Phone Number: ______________________________

Pharmacy Name: ____________________Address:____________________

Pharmacy Number: ______________________________

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Primary Insurance: ______________________________________________

Address: ______________________________________________

Insured Name: ______________________________________________

Insured Relationship to Pt:____________ Insured Date Of Birth: ________________

Subscriber ID: ________________________ Group Number: ________________

Secondary Insurance: ______________________________________________

Address: ______________________________________________

Insured Name: ______________________________________________

Insured Relationship to Pt:____________ Insured Date Of Birth: ________________

Subscriber ID: ________________________ Group Number: ________________

## Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Premier Oncology for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

Signature of Responsible Party: ______________________________________ Date: ___________

## Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company.
I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: ______________________________________ Date: ___________

**Patient Name:** ______________________________

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**FAMILY HISTORY: Please list any serious illnesses that have occurred in your family.**

| **Relative** | **Disease** | **Relative** | **Disease** |
|---|---|---|---|
| Mother | | Paternal Grandmother | |
| Father | | Paternal Grandfather | |
| Sister(s) | | Maternal Aunt | |
| Brother(s) | | Maternal Uncle | |
| Daughter(s) | | Paternal Aunt | |
| Son(s) | | Paternal Uncle | |
| Maternal Grandmother | | Others | |
| Maternal Grandfather | | | |

**PREVIOUS SURGERY:** Please list all operations you have had:

| Type of Surgery | Month / Year | City |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**CURRENT MEDICATIONS:**

| Name of Medication | Dosage | How often taken | Taken for |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ALLERGIES FROM MEDICATION:**

Please list any medications that you have adverse or allergic reactions to:

| Name of Medication | Reaction |
|---|---|
| | |
| | |
| | |

**Patient Name:** ___________________________________________

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PAST MEDICAL HISTORY: Please list all diseases you have had:

1.______________________ 2.____________________ 3.________________________

4.______________________ 5.___________________ 6.________________________

SOCIAL HISTORY: Occupation:_________________________
Alcohol: 0 Yes 0 No Frequency_________ Years______________
Smoking: 0 Yes 0 No Recreational drug use: 0 Yes 0 No
Exercise: 0 Yes 0 No Caffeine: 0 Yes 0 No
Sexually active: 0 Yes 0 No Married: : 0 Yes 0 No
Children: 0 Yes 0 No Travel outside US:_________,_________,_________

Review of Systems:

**Allergy:**
□ Runny Nose □ Scratchy Throat □ Itchy Eyes □ Ear Fullness □ Sinus Congestion
□ Shortness of Breath

**Breast:**
□ Lump right breast □ lump left breast □ Nipple Discharge □ Nipple Retraction
□ Skin Changes **Last Mammogram:** ___________________________________________

**Respiratory:**
□ Shortness of breath □ Chest pain □ Chest Congestion □ Cough □ Bloody sputum □ Asthma

**Cardiology:**
□ Dizziness □ Chest Pain □ Palpitations □ Leg edema □ Shortness of breath □ Varicose veins
□ Heart Murmur □ Leg pain with walking □ Hypertension

**Constitutional:**
□ Weight gain □ Loss of appetite □ Fever □ Weakness □ Weight loss □ Fatigue □ Night sweats □ Pain

**Dermatology:**
□ Rash □ Mole □ Lumps □ Dry or sensitive Skin □ Hives □ Acne □ Skin lesion

**Endocrinology:**
□ Fatigue □ Polydipsia □ Polyuria □ Weight loss □ Sleep Disturbances □ Cold intolerance
□ Heat intolerance □ Diabetes □ Thyroid disease □ Increased appetite

**ENT:**
□ Cold □ Cough □ Epistaxis □ Hearing loss □ Change in voice □ Sore throat □ Wear hearing aids
□ Ringing in ears □ Sinus pain □ Difficulty swallowing □ Vertigo □ Nasal congestion □ Nasal drainage

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**Female Reproductive:**
□ Hot flashes □ Abnormal vaginal discharge □ Heavy periods □ Dyspareunia □ Dysmenorrhea □ Infertility □ Frequent yeast infections □ Pelvic pain □ Breast pain □ Nipple discharge □ **Use of oral contraceptives or hormone replacement therapy** □ Irregular periods

**Male Reproductive:**
□ Difficulty with erection □ Diminished sexual drive □ Penile discharge □ Incontinence

**Gastroenterology:**
□ Blood in stool □ Diarrhea □ Vomiting □ Constipation □ Nausea □ Dysphagia □ Abdominal pain □ Heartburn □ Hemorrhoids □ Black stool □ Change in bowel habit

**Hematology/Lymph:**
□ Swollen glands □ Fatigue □ Loss of appetite □ Varicose veins □ Easy bruising □ Blood transfusion □ Nose bleeds □ Anemia

**Musculoskeletal:**
□ Joint stiffness □ Leg cramps □ Joint pain □ Joint swelling □ Sciatica □ Osteoporosis treatment □ Fracture □ Carpal tunnel □ Rt leg swelling □ Back pain □ Tingling and numbness of extremities □ Left leg swelling □ Arm and leg weakness □ Arm and leg pain □ Arm and leg numbness □ Broken bones

**Neurology:**
□ Headache □ Tingling numbness □ Seizures □ Insomnia □ Memory loss □ Dizziness □ Gait abnormality □ Rt. Leg weakness □ Left leg weakness □ Rt sided weakness □ Aphasia/speech difficulty □ Syncopal episodes □ Left upper extremity weakness □ Vertigo □ Problems with memory

**Ophthalmology:**
□ Diminished vision □ Eye irritation □ Drainage from eyes □ Loss of vision □ Wear glasses □ Cataracts □ Blurring of vision

**Psychology:**
□ Depression □ High stress level □ Sleep disturbances □ Suicidal ideation □ Eating disorder □ Mental or physical abuse □ Anxiety □ Schizophrenia

**Urology:**
□ Difficulty urinating □ Blood in urine □ Frequent urination □ Urinary incontinence □ Voiding dysfunction □ Nocturia □ Kidney stone

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PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: ______________________________ Today's Date :__________

Referred by: ______________________Primary Care Physician:______________________

**RELEASE OF INFORMATION:**
I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ______________________________Date:________

**PAYMENT POLICY:**
**Medicare:** We will accept assignment on all Medicare claims. Patients are responsible for meeting their annual deductible and paying their 20% coinsurance. We do file with secondary/supplemental carriers; however, in the event that the secondary does not pay within 60 days, patients will be balance billed. Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know immediately so we can update your records and advise you if we are a participating provider.
**HMO, PPO and all other Managed Care patients:** You will be responsible for paying your annual deductible, co-payment, coinsurance, charges for cosmetic services and any other non-covered charges, supplies, or services.
**Commercial Patients:** Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay, at the time of service, all deductible and coinsurance amounts as disclosed by your insurance carrier during the verification process. If we are unable to verify insurance coverage, you will be responsible for 35% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature ______________________________Date:____________

**MEDICARE PATIENTS ONLY:**
This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that pay or if they require it for the proper consideration of a claim. Please read and sign the following statement: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card ______________________________Date:____________

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over', we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap Card ______________________________Date: ______________

**DELIQUENT ACCOUNT POLICY:**
Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

Signature: ______________________________Date:________________

Consent for Treatment
**I voluntarily give my permission to the health care providers of Premier Oncology to provide medical services to me, including any procedures like bone marrow, biopsy and aspiration. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Premier Oncology, or until I withdraw my consent in writing.**

Signature of the patient: ______________________________ Date: ______________

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## Consent to Disclose / Release Health information

From: ______________________________________________________________

Address: ____________________________________________________________

Attention: ___________________________________________________________

Phone #: ____________________________________________________________

Fax #: ______________________________________________________________

Other Instructions: ____________________________________________________

**Release health information to:**

☐ Premier Oncology Consultants
12121 Richmond Avenue, Suite 226
Houston, TX 77082
Phone: 281-556-6622
Fax: 281-647-7767

☐ Premier Oncology Consultants
18400 Katy Freeway, Suite 320
Houston, TX 77094
Phone: 281-647-7766
Fax: 281-647-7767

**Authorization**

I authorize Premier Oncology Consultants to obtain copies of my health and medical information pertaining to my medical history including pathology, laboratory, imaging, operative and other diagnostic and treatment notes and reports.

I understand that the health care information will be used for further treatment and evaluation purposes.

Signature of Patient: ___________________________ Date: ________________________

Printed Name of Patient: __________________________ Date of Birth: ________________