NEW PATIENT INFORMATION

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____
Work Phone: _____

Social Security #: _____
Date of Birth: _____

For Office Use
Date Called: _____
Appt Date & Time: _____
Dr Seeing: _____
Type of insurance: _____
Authorization needed? ___ Yes ___ No
Authorization Number:_____
ID Number: _____
Secondary Insurance: _____
Medical Records: bring ___ fax ___ mail ___
Reason for referral:
_____
Office: Grosse Pointe Woods Warren Macomb Twp
Referring Physician: _____

Please verify that the above information is correct then complete the remainder of the outpatient information form.

In what language do you prefer to discuss your health care? _____

Would you like an interpreter? ☐ Yes ☐ No

Do you have any learning barriers? ☐ Yes ☐ No
How do you want to receive information? IE: written, reading, hearing or viewing?

Do you require any assistance such as a sign language interpreter? ☐ Yes ☐ No

Do you have an Advanced Directive? ☐ Yes ☐ No

☐ Power of Attorney ☐ Patient Advocate ☐ Living Will ☐ DNR
Please show the MA your documentation of the above checked so we can make a copy for your file.

Would you like information regarding Advanced Directives? ☐ Yes ☐ No

Hospital of Preference:
Beaumont Grosse Pointe Mt Clemens St John Henry Ford Macomb
Wm Beaumont Hospital-Troy St John Macomb Other: _____

How were you referred to our office?
_____ Primary Care Physician
_____ Surgeon or Sub-specialist Name: _____ Phone: _____
_____ Friend or Family Member
_____ Insurance Plan
_____ Other (Please specify _____)

Name of your Primary Care Physician: _____ **Phone**: _____

Names of other physicians that you see and would like reports sent to:

Name	Specialty	Phone Number

In general, the HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondences to the patient's office instead of to the patient's home.

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

☐ Home Telephone: ( )_____
- ☐ Ok to leave detailed message
- ☐ Leave message with call back number only

☐ Work Telephone: ( )_____
- ☐ Ok to leave detailed message
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ Ok to mail to my home address as listed above
- ☐ Ok to mail to my work address _____
- ☐ Ok to fax information to: Name _____ Fax No: ( )_____

☐ Other: _____

Also, to give information to other physicians, spouses, significant others, family members or guardians, we must have written permission. Please state whom it is ok to give your personal health information to:

Emergency Information:

Contact Person: _____
Relationship: _____
Home Phone: ( )_____ Work Phone: ( )_____

Persons with whom we may discuss your care:

Name	Relationship	Phone

Name:_____

Medication Information

Medications/vitamins/herbal meds that you are currently taking

Medications/Vitamins	Dose	How many times a day taken

Pharmacy Name: _____

Pharmacy Number: ( )_____

Do you have prescription coverage? Yes ___ No ___

Do you have a prescription copay? Yes ___ No ___ Amt: $____

Allergies:

Drug	Reaction

Have you had any surgeries?

Type of Surgery	Date of Surgery

Please check off whether you currently have or have experienced any of the following problems in the past.

____ Heart attack	____ Thyroid Disease	____ Irregular Heart Beat
____ Chest Pain	____ High Cholesterol	____ Emphysema
____ Stroke	____ Depression	____ Asthma
____ Diabetes	____ Heart Failure	____ Stomach Ulcer
____ High blood pressure	____ Tuberculosis	____

Gynecologic History

Age started first menstrual period ____ Date of last menstrual period ____

Age of first full term pregnancy _____ Do you do self breast exams? No ____ Yes ____

Number of pregnancies ____ Number of children ____ Any masses found? No ____ Yes _____

Menopause? N ____ Yes ____ Age started _____

Hormone Replacement Therapy? No ____Yes ____ How many years taking? ____

Hysterectomy? No ____ Yes ____

Ovaries Removed? No _____Yes ____

Name: _____

Habits:

Do you drink alcohol? Yes ___ No ___

What type?

___ Beer

___ Wine

___ Liquor (type_____)

How many at a time?

1-2 ___ 3-5 ___ >5 ___

How often?

___ Daily

___ Weekly

___ Monthly

Have you drank in the past? ___ Yes ___ No

When did you quit? _____

Do you use tobacco? Yes ___ No ___

What type?

___ Cigarettes

___ Chewing tobacco

___ Pipe

___ Cigar

How much per day? _____

For how many years? _____

Are you a former smoker? Yes ____ No ____

What? __Cigarettes ___Pipe ___Cigar

How many packs per day? _____

How long ago did you quit smoking? _____

Do you or did you ever abuse prescription or illegal drugs? Yes ___ No ___

What type? _____

When? _____

Home Situation:

Marital Status: Married Single Widowed Divorced

Sex: Male Female

Who do you live with?

____ Spouse

____ Parents

____ Children (Names: _____)

____ Self _____Other

Are you on disability? ___ Yes ___ No

Reason: _____

When? _____

Do you feel safe at home? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No

Occupation: _____ Employer: _____

Retired: ☐ Yes ☐ No Former Employer: _____

If yes, when? _____

Family History

Relation	Alive	Deceased	Age	Cause of Death
Mother				
Father				
Sib (bro/sis)				
Sib (bro/sis)				
Sib (bro/sis)				
Child				

Name: _____

Have any of your blood relatives had:

Cancer	Yes ____	No ____	Who _____
Tuberculosis	Yes ____	No ____	Who _____
Diabetes	Yes ____	No ____	Who _____
Heart Attack	Yes ____	No ____	Who _____
High Blood Pressure	Yes ____	No ____	Who _____
Stroke	Yes ____	No ____	Who _____
Bleeding Disorder	Yes ____	No ____	Who _____
Anemia	Yes ____	No ____	Who _____

Please check off whether you currently have or have experienced any of the following problems in the past.

System	***Symptoms***
Constitutional:	unexpected weight loss, weight gain, fever, chills, fatigue, insomnia, decreased appetite
Eyes:	corrective lenses, blurred/double vision, eye pain, redness, watering, Glaucoma, cataracts
Ears/Nose:	decreased hearing, nose bleeds, ringing in ears, ear infections, earaches
Mouth/Throat:	sores, difficulty swallowing, painful swallowing, hoarseness, dental problems
Cardiovascular/: **Pulmonary**	chest pain, palpitations, fainting, murmurs, snoring short of breath, wheezing, cough, tightness
Gastrointestinal:	heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stools, hemorrhoids, abdominal pain
Genitourinary:	frequency, urgency, difficult / painful urination, flank pain, impotence, blood in urine, up at night
Musculoskeletal:	joint pains, swelling, redness, muscle pain, walk with cane or walker, back pain
Skin:	skin changes, poor healing, rash, itching, redness
Neurologic:	numbness / tingling, unsteady gait, dizziness, seizure, headaches, blackouts, weakness
Psychiatric:	anxiety, depression, hallucinations, sexual dysfunction

If you have reviewed all of the above conditions and have NOT experienced any of these, please check here _____

Name: _____

*****PLEASE NOTE: In order for the office to be able to fill the appointment time that you will not be able to use, we require a 24-hour notice for missed appointments. If you DO NOT call and cancel your appointment, there will be a $20 missed appointment fee assessed to you the patient. *** Thank you.**

Revised 01/2012 cm

Dear Patient:

We are required to have your signature on file. In that we utilize computer generated claim forms, we would appreciate your signing below in leau of signing the actual claim form.

INSURANCE AUTHORIZATION
AND
MEDICAL INFORMATION RELEASE

Patient Name

Insurance Company Name and Policy/Contract Numbers

"I authorize the release of any medical information necessary to process this claim and further authorize payment of medical benefits to the provider listed below for services rendered."

Patient Signature Date

St John Hospital and Medical Center
Great Lakes Cancer Management Specialist
Robert J. Leonard, M.D., F.A.C.P.
Daniel J. Lehman, M.D., F.A.C.P.
Laura A. Biernat, M.D., F.A.C.P.
Jerome E. Seid, M.D., F.A.C.P.
Muhammed S. Shurafa, M.D., F.A.C.P.
Wajahat A. Khan, M.D., F.A.C.P.
Carrie L. Dul, M.D., F.A.C.P.
Tariq Sabir, M.D., F.A.C.P.

VAN ELSLANDER CANCER CENTER
19229 Mack Avenue Suite 24
Grosse Pointe Woods, MI 48236
(313) 884.5522

23 MI MEDICAL OFFICE BLDG
17900 23 Mile Ste 402
Macomb Township, MI 48044
(586) 868.9090

MACOMB PROFESSIONAL BLDG
11885 E. 12 Mile Rd Ste 100A
Warren, MI 48093
(586) 576.1615

St John Hospital and Medical Center
Great Lakes Cancer Management Specialist
Practice Limited to Medical Oncology and Hematology

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Tariq Sabir, M.D., F.A.C.P.

Dear Patient,

Welcome to our practice. It is our objective to do everything possible to make sure that your experience with our office runs as smoothly and efficiently as possible. In order to help ensure this happens, please do the following:

1. Completely fill out the enclosed patient form and bring it to the office with you at the time of your initial visit. Please make sure to list an emergency contact and all the medications you are taking. Please bring all your medication bottles with you to your first visit and a medical assistant will help with this section. Also, anytime you have a new medication added, please bring the bottle in so that we can update the medication list in your chart. If you discontinue a medication, please be sure to let a medical assistant know so it can be noted in your chart.

2. Bring in all current insurance cards and a photo identification card. **Please be aware that we will be collecting your copays and balances as you check in each visit.**

3. If you have an HMO as your primary or secondary insurance, you must bring in a referral form for each visit.

When you come into the office for the first time, please give your completed Patient Information Form, Insurance Cards and Photo ID to the person at the window when you sign in. The physician will see you and discuss your case which will include a complete history and physical exam.

If you have any questions prior to your first visit, please do not hesitate to call. We look forward to working together as your health care team to insure you receive the best possible care.

Sincerely,

Great Lakes Cancer Management Specialists

Van Elslander Cancer Center ▪ 19229 Mack Ave., Suite 24 ▪ Grosse Pointe Woods, MI 48236 ▪ P: 313-884-5522 ▪ F: 313-884-6054
23 Mile Rd Medical Office Bldg ▪ 17900 ▪ 23 Mi Rd Ste 402 ▪ Macomb Twp MI 48044 ▪ P: 586-868-9090 ▪ F: 586-868-9005
Macomb Professional Building ▪ 11885 E. 12 Mile Rd Ste 100A ▪ Warren, MI 48093 ▪ P: 586-576-1615 ▪ F: 586-576-1628