FOLLOW-UP PATIENT INFORMATION

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

Social Security #: _____
Date of Birth: _____
Marital Status: Married Single Widowed Divorced
Occupation: _____

Sex: Male Female
Employer: _____

For Office Use
Date Called: _____
Appt Date & Time: _____
Dr Seeing: _____
Type of insurance: _____
Secondary Insurance: _____
Hospital: SJH BSH HFHM WBH RD
Medical Records from hospital on chart:
___ Yes ___ No
Office: GPW Macomb Twp WRN E China

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: _____

Name of your Primary Care Physician: _____

Address and phone number of your primary physician:

_____
_____
_____

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

Persons with whom we may discuss your care:

Name	Relationship	Phone

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.

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

Name	Specialty	Phone Number

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

Bring this form, insurance card/s, referral forms (if required by your insurance company) and picture ID.

Signature: _____ **Date:** _____

*****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 Aug, 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.
Daniel J. Lehman, M.D.
Laura A. Biernat, M.D.
Jerome E. Seid, M.D.
Muhammed S. Shurafa, M.D.
Wajahat A. Khan, M.D.
Carrie L. Dul, M.D.
Tariq Sabir, M.D.

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

SJHMC DOCTORS PARK
4014 River Rd Bldg #1
East China, MI 48054
(810) 326.1229

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.

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