



Oncology & Hematology

Specialist, P.A.

Mountain Lakes Office
333 Route 46 West Mountain Lakes
New Jersey, 07046
973.316.1701

Morristown Office
Simon Cancer Center,
Morristown Memorial Hospital
100 Madison Avenue, Suite 3402
Morristown, NJ 07962
973.267.9543

Today's date:

PCP:

Patient Information

Last name:

Mr. Miss

Gender: Male Female

First name:

Mrs. Ms.

Age:

Middle name:

Birth date:

Is this your legal name? Yes No

Marital Status:

If not, what is your legal name?

Social Security No:

(Former name):

Home Phone No:

Street Address:

City:

P.O. Box:

ZIP Code:

State:

Occupation:

Employer:

Employer Phone:

Chose clinic because/Referred to clinic by (please check one box): Dr.

Insurance Plan Yellow Pages Family Hospital Friend Close to home/work Other

Other family members seen here:

Your Local Pharmacy

Town:

Phone:

Insurance Information **(Please give your insurance card to the receptionist.)**

Person responsible for bill:

Birth date:

Address (if different):

Home Phone No:

Is this person a patient here? Yes No

Occupation:

Employer:

Employer Address:

Employer Phone:

Is this patient covered by insurance: Yes No

Please indicate primary insurance:

Subscriber's name:

Birth date:

Subscriber's S.S. no.:

Group No:

Policy No:

Co-payment: \$

Patient's relationship to subscriber:

Self

Spouse

Child

Other

Name of secondary insurance (if applicable):

Subscriber's name:

Group No:

Policy No:

Patient's relationship to subscriber:

Self

Spouse

Child

Other

In Case of Emergency

Name of local friend or relative:

Relationship to patient:

Home Phone No:

Work Phone No:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Oncology & Hematology Specialists, P.A. or insurance company to release any information required to process my claims.

Patient/Guardian Signature

Date:



Original Date:

Dates Revised:

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: Gender: Male Female

Marital Status: Birth date:

Previous or Referring Doctor: Date of Last Physical Exam:

Personal Health History

Childhood Illness: Measles Polio Mumps Rubella Rheumatic Fever Chickenpox

Immunizations and dates:

Tetanus Pneumonia Influenza

Hepatitis Chickenpox MMR (Measles, Mumps, Rubella)

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

OTHER HOSPITALIZATIONS

Year	Reason	Hospital
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Are you prone to "binge" drinking? Yes No

Do you drive after drinking? Yes No

Tobacco

Do you use tobacco? Yes No

Cigarettes – pks./day Chew - #/day

Pipe - #/day Cigars - #/day

of years Or year quit

Sex

Are you sexually active? Yes No

If yes, are you trying for a pregnancy? Yes No

If not trying for a pregnancy list contraceptive or barrier method used:

Any discomfort with intercourse? Yes No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? Yes No

Personal Safety

Do you live alone? Yes No

Do you have frequent falls? Yes No

Do you have vision or hearing loss? Yes No

Do you have an Advance Directive or Living Will? Yes No

Would you like information on the preparation of these? Yes No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes No

MENTAL HEALTH

Is stress a major problem for you? Yes No

Do you feel depressed? Yes No

Do you panic when stressed? Yes No

Do you have problems with eating or your appetite? Yes No

Do you cry frequently? Yes No

Have you ever attempted suicide? Yes No

Have you ever seriously thought about hurting yourself? Yes No

Do you have trouble sleeping? Yes No

Have you ever been to a counselor? Yes No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every days

Heavy periods, irregularity, spotting, pain, or discharge? Yes No

Number of pregnancies number of live births

Are you pregnant or breast-feeding? Yes No

Have you had a D&C, hysterectomy, or Cesarean? Yes No

Any urinary tract, bladder, or kidney infections within the last year? Yes No

Any blood in your urine? Yes No

Any problems with control of urination? Yes No

Any hot flashes or sweating at night? Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? Yes No

Any blood in your urine? Yes No

Any problems with control of urination? Yes No

MEN ONLY

Do you usually get up to urinate during the night? Yes No

If yes, # of times

Do you feel pain or burning with urination? Yes No

Any blood in your urine? Yes No

Do you feel burning discharge from penis? Yes No

Has the force of your urination decreased? Yes No

Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No

Do you have any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Date of last prostate and rectal exam? Yes No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

- | | | |
|------------------------------------|--------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Skin | <input type="checkbox"/> Chest/Heart | <input type="checkbox"/> Recent changes in: <input type="text"/> |
| <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Back | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestinal | <input type="checkbox"/> Energy level |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Bladder | <input type="checkbox"/> Ability to sleep |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Bowel | <input type="checkbox"/> Other pain/discomfort |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Circulation | |



Cancer Family History Questionnaire

Personal Information

Patient Name: Gender: Male Female Age:

Health Care Provider: Date of Birth:

Please mark below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, cousins, great-grandparents, nieces, nephews, half-siblings, grandchildren

CANCER	You	Age of Diagnosis	Siblings/Children	Age of Diagnosis	Mother's Side	Age of Diagnosis	Father's Side	Age of Diagnosis
<i>For example: Colon/rectal cancer</i>	<i>None</i>	<i>----</i>	<i>Brother</i>	<i>36 yrs</i>	<i>Aunt Cousin</i>	<i>44 yrs 58 yrs</i>	<i>Grandfather</i>	<i>65 yrs</i>

BREAST AND OVARIAN CANCER

Breast Cancer (Male or Female)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer (Peritoneal/Fallopian tube)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer in both breasts OR multiple primary breast cancers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic cancer or aggressive prostate cancer* (*Gleason Score ≥ 7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you of Ashkenazi Jewish descent?	<input type="radio"/> Yes <input type="radio"/> No							

COLON AND ENDOMETRIAL CANCER

Endometrial (Uterine) cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon/rectal cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer (Peritoneal/Fallopian tube)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach (Gastric)/Small bowel cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney, urinary tract, biliary tract cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sebaceous adenomas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 or more lifetime colon/rectal polyps (specify #)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MELANOMA

Melanoma

Pancreatic cancer

OTHER CANCER (specify cancer type)

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? Yes No

If Yes, Who?

What gene(s)?

What was the result?

Patient's Signature:

Date:

Health Care Provider's Signature:

Date:

OFFICE USE ONLY

Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

If Yes, which test? BRACAnalysis® with Myriad myRisk® Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk

COLARIS®PLUS with Myriad myRisk COLARIS AP®PLUS with Myriad myRisk Single Site Testing Myriad myRisk Update

Other:

Follow-up appointment scheduled: Yes No

Date of next appointment:

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com
Myriad, the Myriad logo, BRACAnalysis, COLARIS, COLARIS AP, MELARIS, Myriad myRisk and the Myriad myRisk logo are either trademarks or registered trademarks of Myriad Genetics, Inc., in the United States and other jurisdictions, ©2016, Myriad Genetic Laboratories, Inc MGALLFHQ 06-2016



ONCOLOGY & HEMATOLOGY SPECIALISTS, P.A.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the health insurance portability & Accountability Act of 1988 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been advised of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and that a copy of these practices was made available to me. I understand that this organization has the right to change or update its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment and payment of health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if agreed, this organization must be bound to abide such restrictions.

Patient Name	<input type="text"/>	Signature	<input type="text"/>
Other	<input type="text"/>	Relationship to Patient	<input type="text"/>
Date	<input type="text"/>		

OFFICE USE ONLY

I attempted to obtain the patient's/designee's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

Date	<input type="text"/>	Initials	<input type="text"/>	Reason: unable to sign	<input type="text"/>	Refused to sign	<input type="text"/>
------	----------------------	----------	----------------------	------------------------	----------------------	-----------------	----------------------



ONCOLOGY & HEMATOLOGY SPECIALISTS, P.A.

HIPAA CONSENT

Oncology & Hematology Specialists (OHS) requires written authorization to discuss your care with family, friends or others.

Patient Name

Date of Birth

Street Address

City/State/ZIP

The following names listed are those that I give Oncology & Hematology Specialists authorization to discuss my care:

Relationship Phone Number

Relationship Phone Number

Relationship Phone Number

Or, **DO NOT PROVIDE** health information to anyone but me.

Do you have a Medical Power of Attorney Yes No

If yes: Name

Relationship Contact Number

This authorization will remain in effect until I have completed and signed an updated authorization or I provide a written notice of revocation to Oncology & Hematology Specialists.

If I have questions about disclosure of my health information, I can contact OHS at 973 316-1701 or email via the patient portal.

Patient/Legal Representative

Date

I need not sign this form in order to assure treatment.
(To be completed if patient refuses to sign acknowledgement)

Date

Name of person providing notice

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner for appointments and test results:

Check all that apply

Home/Cell Number Work Number

- Leave message with appointment date and time
- Leave message with test results
- Leave message with dietary restrictions for scheduled tests
- Leave a call back number only
- Do not leave message

OHS may leave PHI on my voice mail/answering machine Yes No

OHS may leave PHI with an adult who answers your home phone Yes No

If you use a transportation service to bring you to appointments/treatments, may we release limited PHI such as end of treatment time to the driver/transportation company? Yes No

Patient/Legal Representative

Date