Pt. Intake Form

Dear Patient,

We are in the process of changing over to Electronic Medical Records (EMR) System. In order to accomplish that, we need your help to update our records to speed up that process. We will need you to complete this form in its entirety before we can call you back.

In addition, you will now be able to sign up for Patient Portal, or SEE YOUR CHART, where you will be able to access a portion of your medical records from home. This will save you some time when wanting to see your lab work, see when your next appointment is, or to any other healthcare providers you may be seeing.

Thank you for your cooperation and your patience. Please do not leave any fields blank. We will have to ask for these fields to be completed if you do. Thank you.

Name: _____
First Middle Initial Last Suffix

SALUTATION or Name Wish to be called: _____

SEX: Male Female Date of Birth: _____

Social Security Number: _____

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

RACE: American Indian Alaskan Native Asian Black or African American Native Hawaiian

Other Pacific Islander White Other

Address (primary):_____

_____

Any other address you would like to have on file other than home: _____

_____

PHONE NUMBERS: Home: _____

Mobile (Cell):_____

Work: _____

Other: _____

Which number would you like to be your primary contact number for reminders (NOTIFICATION PREFERENCE)? Home Cell Work Other

E-MAIL ADDRESS (necessary for SEE YOUR CHART): _____

EMPLOYER: _____

PREFERRED LANGUAGE: _____

Spouse Name and Number: _____

Contact Person if other than spouse & contact information & relationship to patient:

_____

Do you have any ADVANCED DIRECTIVES in place? Living Will YES or NO

If so, please provide a copy to the staff. Durable Power of Attorney YES or NO

Do Not Resuscitate YES or NO

Insurance Information: (We will take a copy of your insurance cards, but need the following information as well.)

RESPONSIBLE PARTY (Which member of your family carriers the insurance plan): Self or Other

IF OTHER, THEIR NAME: _____

IF OTHER, LIST RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY'S SS#: _____ & DATE OF BIRTH: _____

RESPONSIBLE PARTY'S EMPLOYER: _____

Any Health Care Providers (MD'S, NP'S or PA'S) that you see outside of this clinic and their specialty and address. Use back of this page if needed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Any other medical problems that you have other than what you see our doctors for:

_____

_____

_____

_____

Have you ever had any surgery? If so, what and approx. when?

_____

_____

_____

_____

Have you ever had a blood transfusion? YES or NO

If yes, did you ever have a reaction to blood products? YES or NO

Does your religion prohibit you from taking blood products? YES or NO

Do you <u>currently</u> use tobacco products? YES or NO If so, what form of tobacco? _____

If yes, would you like information to stop using tobacco products? YES or NO

Have you <u>ever</u> used tobacco products? YES or NO If yes, how long ago did you quit? _____

When was your last Flu shot? _____

When was your last pneumonia shot? _____

PREFERRED PHARMACY with street address: _____

_____

Mail Order Pharmacy: _____

_____

List of ALL food and drug allergies that you have and type of reaction you have to them.

_____

_____

Please list ALL of your current medications. Please include the name, dose and how many times a day you take them. If you do not know the names of your medicines, please either bring them with you the next time you come, or mail us a list of them as soon as you get home. Please include all vitamins and supplements and any over the counter medications also. You may use the back of this page if you need to.

Medication Name:	Strength:	How you take it:	Who prescribed it:
Example: Vitamin D	1000mg	1 time a day	Dr. John Doe

Thank you for your help with this transition. This will help us make a smoother change over and allow us to better serve you. It will also be information that you will have access to with SEE YOUR CHART. Once you have provided us with an email address, we will email you a link that you can go online to register for this feature. All of this information will be available to you, plus a summary of your lab and your visit with us on clinic days.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I give consent to Mid-Illinois Hematology & Oncology Associates, Ltd. to use my private health information for treatment, payment, and healthcare operations.

I hereby authorize release of information necessary to file a claim with my insurance company(s) and assign benefits otherwise payable to me to the provider listed on the claim.

Although I have requested the doctor to bill my insurance company on my behalf, I understand that it is my responsibility to make sure the bill is paid in a reasonable amount of time. If for any reason any portion of the bill is not paid by insurance, I agree to make arrangements for prompt payment of the balance.

A copy of this signature is as valid as the original.

Signed: _____ Date: _____