

Appointment Date: _____ Acct #: _____ (office use only)

Name: _____ **Social Security#:** _____

Address: _____ **Drivers License Number:** _____

City: _____ State: _____ Zip Code: _____

Sex: M F **Birthdate:** _____ Age: _____ Single Married Widowed Separated Divorced

Home Phone: _____ Cell Phone: _____

Known Allergies: _____

Pharmacy Name & Phone: _____

Patient Employer: _____ Occupation: _____

Business Address: _____ Phone: _____

Name of Referring Doctor: _____

Name of Spouse or Resp. Party: _____ Social Security#: _____

Address (if different than above): _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name & Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Co. Name: _____

Phone: _____ **DOES YOUR INSURANCE REQUIRE ANY PRE AUTHORIZATION?**

Subscriber Name (if other than patient) _____ DOB: _____ Relationship: _____

ID#: _____ Group/Plan#: _____

SECONDARY or SUPPLEMENTAL INSURANCE INFORMATION

Insurance Co. Name: _____

Phone: _____

Subscriber Name (if other than patient) _____ DOB: _____ Relationship: _____

ID#: _____ Group/Plan#: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payment directly to the Physician for all medical benefits, if any, otherwise payable to me for services rendered, realizing I am responsible to pay for non covered services. I authorize the Physician to release any information in the course of my treatment necessary to process insurance claims.

Patient Signature: _____ Date: _____

DATE: _____

NAME: _____

PATIENT MEDICAL HISTORY

Please "X" the appropriate answer

Have you had any of the following:

| | YES | NO | DESCRIBE DETAILS |
|--|---|---|---|
| SKIN DISORDERS: Chronic Rashes Itching Prior skin cancer | _____ _____ _____ | _____ _____ _____ | |
| BLOOD DISORDERS: Anemia (low blood counts) Bleeding excessively Excessive bruising Bone marrow cancer | _____ _____ _____ _____ | _____ _____ _____ _____ | |
| VISION DISORDERS: Corrective lenses Glaucoma Loss of vision Double vision Blurred vision Eye surgery | _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ | Date(s): |
| HEARING DISORDERS: Loss of hearing Ringing in ears Ear infections Ear surgery | _____ _____ _____ _____ | _____ _____ _____ _____ | Date(s): |
| LUNG DISORDERS: Cigarette smoker Chronic cough History of asthma or emphysema History of bronchitis History of pneumonia Tuberculosis exposure Lung surgery | _____ _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ _____ | How much? Date(s): |

| | YES | NO | DESCRIBE DETAILS |
|---|---|---|--|
| HEART DISORDERS: High blood pressure History of heart murmur Chest pain (angina pectoris) Heart failure Fainting episodes Heart surgery | _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ | How long? Date(s) |
| GASTROINTESTINAL DISORDERS: Difficulty swallowing Heartburn chronically History of ulcer disease Liver disease Nausea & vomiting Diarrhea Constipation Blood in stool Black/tarry stool Gallbladder surgery Appendectomy Other G.I. Surgery | _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ | Date(s): _____ Date: _____ |
| KIDNEY DISORDERS: Urinary infection Hesitancy on urination Blood in urine Pain on urination Urine leakage Prostate surgery (men) Kidney stone | _____ _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ _____ | Date(s): |
| GYNECOLOGY (Women) Number of pregnancies Date of last menstrual period Date last pelvis exam Removal of uterus (hysterectomy) Removal of ovaries Do you take estrogen Breast lumps Prior breast surgery History of Breast cancer History of uterine/cervical cancer History of ovarian cancer | _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ | Date: Date: Date: Date: Date: Date: |

| | YES | NO | DESCRIBE DETAILS |
|--|--|--|---|
| MUSCULOSKELETAL DISORDERS Arthritis Back Surgery Prior fractures Muscle disease | _____ _____ _____ _____ | _____ _____ _____ _____ | Which Joints: Date(s): Dates & which bones? |
| NEUROLOGICAL DISORDERS: Chronic severe headaches History of stroke Seizure Numbness in hands/feet Falling Brain surgery | _____ _____ _____ _____ _____ _____ | _____ _____ _____ _____ _____ _____ | Date(s): |
| CONSTITUTIONAL DISORDERS: Weight loss/gain Loss of appetite Fever (greater than 100) Severe fatigue | _____ _____ _____ _____ | _____ _____ _____ _____ | How much? |
| ENDOCRINE DISORDERS: Diabetes Thyroid disorder Thyroid surgery Sexual dysfunction | _____ _____ _____ _____ | _____ _____ _____ _____ | Date(s) |
| FAMILY HISTORY: Heart disease Diabetes Cancer | _____ _____ _____ | _____ _____ _____ | |

Please list all meds that you take on a regular basis. **(INCLUDE DOSES & FREQUENCY).**
Both prescription and nonprescription (include vitamins).

Please list use and frequency of any other drugs or substance you take
(cocaine, marijuana, alcohol, etc.)

Please list any medical disorders not covered above.

Please list any surgeries not covered above.

Describe allergies to medications or food. What type of reaction.

List information not covered above.

Physician Signature

Date

Revised 12/03

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

Date: _____ **Re:** _____
(Patient's Name)

I authorize **Orange Coast Oncology Hematology Medical Associates, Inc.** to use and disclose the health and medical information of above-referenced patient for the purposes of *Treatment, **Payment and ***Health Care Operations.

***Treatment** (includes activities performed by a health care provider, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

****Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

*****Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Orange Coast Hematology Medical Associates, Inc.'s "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in the consent prior to signing the consent. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that OCOH has already used or disclosed the information in reliance on this Consent.

Signature of Patient

Date

Signature of Person Authorized by Law

Date

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Before starting medical services and treatment or at your first visit, we require all of your insurance information, including a current insurance ID card and any referral or authorization that may be required. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions regarding your insurance coverage prior to your visit, you are welcome to contact our Business Office at 949-723-5178.

UNINSURED PATIENTS

Payment is due in full at the time of service for all office visits, procedures and treatment unless other arrangements are made in advance with our Business Office. We accept cash, checks and major credit cards.

INSURANCE*

It is your responsibility to know the details of your health insurance plan. The patient is responsible for obtaining any required pre-authorization and/or referral for outside lab, diagnostic procedures and x-ray testing. If you are unsure as to where outside testing must be performed, please contact your health plan. Our office will not be held responsible for out of pocket expenses from utilizing the wrong provider or not obtaining pre-authorization. Payments for outstanding patient balances are due within 30 days of the statement date unless other arrangements have been made with our Business Office.

PPO-POS INSURANCE

We will bill your insurance plan. **ALL APPLICABLE CO-PAYMENTS ARE DUE AND WILL BE COLLECTED AT THE TIME OF YOUR VISIT.**

MEDICARE

Our physicians are participating providers with the Medicare program and accept "assignment." The 20% co-insurance is payable by the patient unless supplemental insurance coverage is provided. Please be advised Medicare does not cover self administered injections outside of our office.

LAB TESTS AND OTHER CHARGES

If your visit includes lab tests, x-rays/scans or biopsies, you will receive separate billing from the company performing the processing and evaluation of those tests; e.g., Hoag Hospital, Newport Imaging, Newport Diagnostics, Westcliff Labs, Impath Laboratories, etc. We will provide your insurance billing information to these facilities.

*Insurance is a contract between you and your insurance company. We are a party to this contract in some cases. If we are a party to your insurance, we will handle claims according to our agreements with the insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, usual and customary charges, etc., other than to supply information as necessary. You are ultimately responsible for the timely payment of your account.

I have read and understand the above information.

| | | |
|---------------------------|------------------|-------------|
| Print Patient Name | Signature | Date |
|---------------------------|------------------|-------------|

| | | |
|-------------------------------|------------------|-------------|
| Responsible Party Name | Signature | Date |
|-------------------------------|------------------|-------------|

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