**Premier Oncology**
**New Patient Registration Form** Date:_____________

## Patient Information

Name (first, middle, last):____________________________________Date of Birth:__________________

Social Security Number:________________________Email:_________________________________

Address:_____________________________City:______________________Zip Code:_____________

Phone Number: (_____)_____________Cell Phone: (_____)__________Preferred Number: Home Cell

Marital Status: Single Married Widowed Separated Divorced

Employment Status: Employed Unemployed Retired Disabled Student

Race: Caucasian African American Hispanic Asian Native American Other

Employer:_____________________________________________________________________________

Primary Physician:__________________________*Referring Physician:___________________________

***If referred by the hospital write "hospital" for referring physician, not the physician's name.**

## Pharmacy Information

Name:__________________________________________Phone Number: (_______)_________________

Address:_____________________________________________________________________________

## Emergency Contact

Name:___________________________________Relationship to Patient:___________________________

Home Phone :(_________)______________________Cell Phone: (_________)_________________________

## Insurance Information

**Primary Insurance**

Subscriber's Name:___________________________DOB:___________Relationship to Patient:_____________

Employer:_________________________________Insurance Company:____________________________

Group #:___________________________ID#:________________________Effective Date:_____________

**Secondary Insurance** (if you have one)
Subscriber's Name:_________________________DOB:___________Relationship to Patient:____________

Employer:______________________________Insurance Company:____________________________

Group #:________________________ID#:_______________________Effective Date:_________________

# Medical History

Date:_______/_________/_________

Name:_______________________________________________________ Age:______________
Marital Status (Please Check): Single_____ Married_____ Divorced_____ Separated_____ Widowed______
Primary Physician:_____________________________________________Last Visit:______/______/_____
Referring Physician:___________________________________________Last Visit:______/______/_____

What is the reason for today's visit?______________________________________________________________

**Do you or have you had any of the following symptoms? (Check all that apply)**

______Cancer
______Leukemia
______Diabetes
______Aids
______Hepatitis
______Blood Clots
______Abnormal Bleeding Time
______High Blood Pressure
______Migraines
______Seizures/Epilepsy
______Rheumatic Fever
______Pneumonia
______Heart Condition
______Heart Attack
______Heart Murmur
______Asthma
______Lung Problems
______Emphysema
______Kidney Problems/Infections
______Kidney Stones
______Liver Disease
______Ulcer Disease
______Gastroenteritis
______Gall Bladder Problem
______Hay Fever
______Cellulitis
______Other Problems (Please Describe)__________________________________________________________

**Do you have any of the following allergies? (Check all that apply)**

______Penicillin ______Novocaine ______Aspirin _____Adhesive Tape ______Hay Fever
______Motrin or NSAID's ______Other Allergies (Describe)________________________________________

**Surgical History: List type of surgery and year performed (including inpatient, outpatient, and any hospitalizations)**

______________________________________________________________________________________________

______________________________________________________________________________________________

**Personal Habits: (Do you now or have you ever?)**

Smoke: Y____ N______ Packs Per Day______ Number of Years_______ When Stopped________
Drink: Y____ N______ Beer______ Mixed Drinks_______ How Often _____ When Stopped________
Blood Transfusions: Y______ N______ When:________________ Reason:______________________________
Occupation:____________________________ Exposure to Chemicals/Toxins: Y______ N______ Type:_______

**Travel History: (within the last 6 months)**

Have you traveled out of NJ in last 14 days? Y______ N______ Internationally: Y______ N______
If so, Where?_____________________________________________________________________________________
Are you currently sick? Y______ N_______
If so, Please list your symptoms _______________________________________________________

# Medication List

**Patient Name:** _________________________________**DOB:**_________ _________
**Today's Date:**_____________

| Medication Name | Strength | Frequency |
|---|---|---|
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| Allergies: |
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# Review Of Symptoms

**Name:**_____________________________________________ **Date:**________/________/_________

(Check <u>now</u> for symptoms in the last <u>3 months</u> and check <u>past</u> for symptoms you've had prior to the last <u>3 months</u>)

**Check here if none__**

| **CONSTITUTIONAL SYMPTOMS** | **NOW** | **PAST** | **CARDIOVASCULAR** | **NOW** | **PAST** | **NEUROLOGICAL** | **NOW** | **PAST** |
|---|---|---|---|---|---|---|---|---|
| UNEXPLAINED WEIGHT LOSS | | | CHEST PAIN / TIGHTNESS | | | FREQUENT HEADACHES | | |
| FEVER / NIGHT SWEATS | | | FAINTING | | | MEMORY PROBLEMS | | |
| DAYTIME SLEEPINESS | | | IRREGULAR HEART BEATS | | | SLURRED SPEECH | | |
| FATIGUE/WEAKNESS | | | FAST HEART BEATS | | | TEMPORARY EYE BLINDNESS | | |
| LOSS OF APPETITE | | | SHORTNESS OF BREATH AT NIGHT | | | SEIZURES | | |
| **SKIN** | **NOW** | **PAST** | EXERCISE INTOLERANCE | | | MUSCLE WEAKNESS | | |
| SKIN LESION | | | LEG PAIN WITH WALKING | | | OTHER:________________ | | |
| RASH/ITCHING | | | HEART MURMUR | | | **MUSCULOSKELETAL** | **NOW** | **PAST** |
| CHANGE IN SKIN COLOR | | | OTHER:___________________ | | | PAINFUL/SWOLLEN JOINTS | | |
| OTHER:__________________ | | | **GASTROINTESTINAL** | **NOW** | **PAST** | BACK PAIN | | |
| **EYES** | **NOW** | **PAST** | ABDOMINAL PAIN | | | OTHER:________________ | | |
| CORRECTIVE LENSES | | | DIFFICULTY SWALLOWING | | | **ENDOCRINE** | **NOW** | **PAST** |
| DOUBLE VISION | | | BLOATING | | | GOITER | | |
| BLURRY VISION | | | NAUSEA/VOMITING | | | HEAT / COLD INTOLERANCE | | |
| FEAR OF BRIGHT LIGHTS | | | BLOOD IN VOMIT | | | EXCESSIVE SWEATING | | |
| OTHER:__________________ | | | HEARTBURN | | | FREQUENTLY THIRSTY | | |
| **EARS, NOSE, THROAT** | **NOW** | **PAST** | DIARRHEA | | | OTHER:________________ | | |
| DIFFICULTY HEARING | | | CONSTIPATION | | | **HEMATOLOGIC / LYMPHATIC** | **NOW** | **PAST** |
| DIZZINESS | | | HEMORRHOIDS | | | BLEEDING / BRUISING EASILY | | |
| RINGING IN THE EAR | | | BLACK OR BLOODY STOOLS | | | LUMPS IN NECK / ARMPITS / GROIN | | |
| NOSE BLEEDS | | | OTHER:___________________ | | | LOW BLOOD COUNT | | |
| BLEEDING GUMS | | | **GENITOURINARY** | **NOW** | **PAST** | TRANSFUSIONS | | |
| DENTAL PROBLEMS | | | KIDNEY STONES | | | OTHER:________________ | | |
| SORE THROAT | | | FREQUENT URINATION | | | **ALLERGY / IMMUNE SYSTEM** | **NOW** | **PAST** |
| CHANGE IN VOICE | | | BLOOD IN URINE | | | FREQUENT INFECTIONS | | |
| OTHER:__________________ | | | DIFFICULTY HOLDING URINE | | | ALLERGIES / HAY FEVER | | |
| | | | PAINFUL URINATION | | | AIDS / HIV | | |
| **RESPIRATORY** | **NOW** | **PAST** | SLOW STARTING OF URINE | | | OTHER:________________ | | |
| SHORTNESS OF BREATH | | | URINATING > ONCE AT NIGHT | | | **PSYCHIATRIC** | **NOW** | **PAST** |
| CHRONIC COUGH | | | SEXUAL DYSFUNCTION | | | MENTAL ILLNESS | | |
| SPUTUM | | | OTHER:___________________ | | | DEPRESSION | | |
| COUGHING UP BLOOD | | | **MEN** | **NOW** | **PAST** | NERVOUS OR ANXIOUS | | |
| WHEEZING | | | DISCHARGE FROM PENIS | | | ATTEMPTED SUICIDE | | |
| SNORING | | | SORE ON PENIS | | | DRUG / ALCOHOL ABUSE | | |
| OTHER:__________________ | | | LUMP ON TESTICLES | | | OTHER:_______________ | | |

Please sign below that the information contained on this form is true and correct to the best of my knowledge.

**PATIENT'S SIGNATURE:**________________________________________**DATE** ____________________

<u>I HAVE REVIEWED THE FOLLOWING MEDICAL INFORMATION AND DISCUSSED IT WITH THE PATIENT.</u>

**Today's Date:________________________**

**Patient Name:________________________Date of Birth:________________________**

**Family Health History Questionnaire Hematology/Oncology**

**___ I was adopted so I do not know my family history (skip below list)**

**Check below to report problems your family members have had:**

| | Mother | Father | Sister | Brother | Daughter | Son |
|---|---|---|---|---|---|---|
| Anesthesia Problems | | | | | | |
| Bleeding Disorder | | | | | | |
| Breast Cancer | | | | | | |
| Clotting Disorder | | | | | | |
| Colon Cancer | | | | | | |
| Diabetes | | | | | | |
| Heart Disease | | | | | | |
| Hypertension | | | | | | |
| Kidney Disease | | | | | | |
| Leukemia | | | | | | |
| Lung Cancer | | | | | | |
| Lymphoma | | | | | | |
| Melanoma | | | | | | |
| Multiple Myeloma | | | | | | |
| Ovarian Cancer | | | | | | |
| Stroke | | | | | | |
| Other Cancer (specify) | | | | | | |

**PREMIER ONCOLOGY LLC.**
**NOTICE OF PRIVACY PRACTICES**

**Acknowledgment of Receipt of Notice of Privacy Practices**

**Patient Name:**___________________________________________

**Social Security Number:**__________________________________

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Premier Oncology LLC.

___________________________________________________
**Signature of Patient or Personal Representative**

___________________________________________________
**Print Name of Patient or Personal Representative**

______________________
**Date**

___________________________________________________
Description of Personal Representative's Authority

**CONTACT INFORMATION**

The contact information of the patient or personal representative who signed this form should be filled in below.

**Address:**

__________________________________

__________________________________

**Telephone:**______________________________(day time)_______________________________(evening)

**Premier Oncology LLC, Rajasree Ajay M.D.**
**Patient Consent for Use and Disclosure of Protected Health Information**

I hereby give my consent for **Premier Oncology LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Premier Oncology LLC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Premier Oncology LLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Premier Oncology LLC, Rajasree Ajay M.D.**

With this consent, **Premier Oncology LLC** staff may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Premier Oncology LLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "personal and confidential."

With this consent, **Premier Oncology LLC** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Premier Oncology LLC** restrict how it discloses my PHI to carry out my TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Premier Oncology LLC** to use and disclose my PHI to carryout TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Premier Oncology LLC** may decline to provide treatment to me.

Signature of Patient or Legal Guardian:______________________________________________

Print Patient's Name:______________________________Date:______/________/__________

Print Name of Legal Guardian, if applicable:_______________________________________________

**Premier Oncology LLC.**

**Rajasree Ajay, M.D.**

Board Certified Medical Oncology & Hematology

54 W Jimmie Leeds Road, Suites 11 & 12

Galloway, NJ 08205

Phone: 609-748-1001 Fax: 609-748-1002

Dear Patient and/or Patient's Family:

Under New Jersey Law (26:2H-62) it is the responsibility of the attending physician to inquire of you whether you have an Advanced Directive for Health Care (Living Will). Please advise us. If you have such a document please provide us with a copy that may be included in your office record in this office. Please advise us of any future changes in this written directive.

It is your right under New Jersey Law to have such a written Advanced Directive for Health Care. Should you desire more information about this please inquire of us and we will provide the information.

Kindly acknowledge by signing below that we have fulfilled our obligation to notify you. Note that this paper is not in any way binding, is not a living will and has nothing at all to do with your regular will.

Acknowledged By:

______________________________________________________________________________

Patient Date

______________________________________________________________________________

Family Member if patient unable to sign Date

Interested: _____________

Not Interested: ___________

## PREMIER ONCOLOGY LLC. RAJASREE AJAY M.D. OUR FINANCIAL POLICY

Thank you for choosing Rajasree Ajay M.D as your health care provider. We are committed to your treatment successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read, and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE, if you do not have insurance. Payment may be made by cash, check or debit/credit card.

*Regarding Insurance:* We accept assignment of insurance benefits. You are responsible for any co-pays, co-insurance and deductibles and for payment of any non-paid amounts as per your insurance company. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contact. Regarding Insurance Plans where we are a participating provider, all co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participation provider, please refer to the above paragraph. If your insurance company does not cover the nature of your medical problem you are responsible for payment of bills related to that non-covered medical problem.

**Patients receiving chemotherapy or injections are responsible for verifying their insurance is active at least 24 hrs. prior to their appointment. If insurance has lapsed or is terminated at time of service, the patient will be responsible for full payment of the bill.**

If your insurance company requires you to obtain a referral from your primary care physician in order to see the Specialist, please follow the following procedures to avoid non-payment of your bill by your insurance company.

The patient is responsible for obtaining any necessary referral before the Specialist may see you as a patient.

As per your insurance company, if you do not have the proper referral when you go to a Specialist appointment, we must reschedule your appointment since your insurer will deny payment on all claims not having a proper referral.

The patient is always responsible for keeping track of how many visits to a Specialist each referral will cover. New updated referral and the obtaining thereof is always the patients' responsibility.

Please have your referral sent, fax (609-748-1002) or brought to the office with you at time of visit.

*Missed Appointments:* Please notify us if you are unable to keep your appointment. Please help us to serve you better by keeping scheduled appointments.

Thank you for understand our Financial Policy. Please understand that we are abiding by the rules and regulations of your insurance company. Please let us know if you have any questions or conerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

x________________________________________ Date________________________ Signature of Patient or Responsible Party

x________________________________________ Date________________________ Signature of Co-Responsible Party

# Patient Copy\J

## PREMIER ONCOLOGY LLC NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.\J
Information may be shared among members of the practice where necessary to provide treatment to the patient, obtain payment for the treatment and carry on routine business operation for the practice (TPO).

In addition, the practice may disclose PHI (Protected Health Information) without patient consent or authorization to further certain public policy objectives including:

Where disclosure is required by law;

For a judicial or administrative proceeding;

For public health activities;

To report incidents of abuse, neglect or domestic violence;

For law enforcement purposes;

To advert a serious threat to health and safety;

For nations security and intelligent activities and protective services;

For certain military and veterans activities and benefits;

For health, safety and security of prison inmates or other detainees;

To facilitate organ, eye or tissue donation, and

Coroners, medical examiners, and funeral director

*By law, our practice must have your written permission (authorization) to use or give out your personal medical information for any purpose that is not stated in this notice.*

## Patients' Privacy Right Under HIPPA

The privacy regulations grant patients' the following rights regarding their PHI (Protected Health Information):

The right to Notice of Practice's Privacy Practices for PHI;

The right to inspect and copy their PHI;

The right to request amendment of correction of their PHI;

The right to receive an accounting list that provides information and disclosures of their PHI that were made to third parties for purposes other than treatment, payment and health care operations and other then those disclosure that were authorized by the individual;

The right to request that the practice further restrict the way it uses or discloses their PHI;

The right to request that the practice communicate with them by alternative means or at alternate locations. The practice will do their best to accommodate all reasonable requests.

*If you believe our practice has violate your privacy rights as indicated in this notice, you may file a complaint with our practice in writing or call our office at 609-748-1001 and ask to speak with our Compliance Officer. No one will retaliate or take action against you for filing a complaint. FULL VERSION OF THIS NOTICE-AVAILABLE IN OFFICE.*

**Patient Copy**

# ***Premier Oncology: Patient Bill of Rights***

Receive treatment without discrimination as to race, color, religion, sex, national origins, disability, sexual orientation or source of payment

Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Receive emergency care or be directed to the nearby emergency room based on your condition and needs.

Be informed of the name and position of the doctor who is in charge of your care.

Know the names, positions and functions of any staff involved in your care and refuse their treatment, examination or observation.

A non-smoking environment.

Receive complete information about your diagnosis, treatment and prognosis.

Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

Refuse treatment and be told what the effects this may have on your health.

Participate in all decisions about your treatment.

Review your medical record without charge and obtain a copy of your medical records.

Receive an itemized bill and explanation of all charges.

Complain without fear of reprisal about the care and services you are receiving.