SURINDER VOHRA MD PC

PATIENT INFORMATION/ ASSIGNMENT OF BENEFITS

TLC Cancer Clinic

Account # _____ Today's Date: _____

Patient Name: _____ _____
Last First M.I. Account #

_____ _____ _____
Home Phone Cell Phone Work Phone

Email Address: _____

Note: Your email address could be used by the practice to notify you on how to access information and for specific reminders. It will not be used for two-way communication regarding your medical care. Please contact our office if you have any questions or concerns related to your medical care.

Home Address: _____ Mailing Address: _____
Street Street

_____ _____
City State Zip City State Zip

DOB: _____ Age: _____ ❑ M ❑ F SS# _____ ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other

Race (optional): _____ Ethnicity _____ Preferred Language _____

Employer: _____ _____
Name Telephone

_____ _____
Address Occupation

Responsible Party: _____ _____ _____
Name Relationship Telephone

Emergency Contact
Spouse/Next of Kin: _____ _____ _____
Name Relationship Telephone

Preferred Method of Contact (circle one): Home Phone Cell Phone Work Phone Email Mail

Referring Physician: _____ **Primary Care Physician**: _____

Primary Ins: _____ _____
Telephone

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

Secondary Ins: _____ _____
Telephone

Insured Name: _____ DOB: _____ Group #: _____ Policy #: _____

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Surinder Vohra MD PC.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Surinder Vohra MD PC. The assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Surinder Vohra MD PC.
4. I understand that I have a right to request and receive a Notice of Privacy Practices Surinder Vohra MD PC.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature Date

PAST MEDICAL HISTORY (Have you ever had any of the following?)

□ Arthritis	□ Lupus	□ Anemia
□ HIV	□ Thyroid	□ Diabetes
□ Pancreatitis	□ Reflux	□ Stomach Ulcer
□ Gallbladder	□ Hiatal Hernia	□ Colitis
□ Diverticular Disease	□ Crohn's Disease	□ Liver Disease
□ Kidney Failure	□ Bladder Infections	□ High Blood Pressure
□ Angina	□ Heart Murmur	□ Heart Failure
□ Heart Attack	□ Stroke	□ Irregular Heart Beat
□ Blood Clot	□ Asthma	□ Bronchitis
□ Anxiety	□ Depression	□ Parkinson's
□ Epilepsy	□ Skin Problems	□ GYN Problems

Any other medical problems or illnesses?

_____

_____

_____

Have you ever had any of the following?

Cancers _____

Chemotherapy _____

Radiation _____

PAST SURGICAL HISTORY

Surgery	Date	Facility performed

WOMEN ONLY

Age of first menstruation _____ Date of last period _____

Menses: □ Regular □ Irregular How many days _____

# of pregnancies _____ # of miscarriages/abortions _____

Age at first full term pregnancy _____ Date of last pap smear _____

Date of last mammogram _____ Have you taken hormones (i.e. estrogen, progesterone, etc.) _____

Any unusual bleeding □ No □ Yes Nipple Discharge? □ No □ Yes

Do you do self-breast exams □ No □ Yes How often do you do self-breast exams? _____

Any breast lumps/masses □ No □ Yes

MEDICATIONS (Please list all prescription meds, over the counter and home remedies)

Name of medication	Strength	How Often	Reason for taking

Do you use any over the counter medicines including aspirin or Tylenol?

_____

Do you use any alternative medicines, i.e. herbal supplements or home remedies?

_____

ALLERGIES (Please list all allergies to medications and describe the reaction)

_____

_____

_____

Are you allergic to x-ray dye? _____

FAMILY HISTORY

Number of brothers? _____ Number of sisters? _____

Do you have children? □ No □ Yes

Number of sons _____ Number of daughters _____

Family history of Cancer, Blood Disorders (i.e. anemia, blood clots)

		Type			Type
Mother	□ Yes □ No	_____	Father	□ Yes □ No	_____
Sister (s)	□ Yes □ No	_____	Brother (s)	□ Yes □ No	_____
M. Grandmother	□ Yes □ No	_____	P.Grandmother	□ Yes □ No	_____
M. Grandfather	□ Yes □ No	_____	P. Grandfather	□ Yes □ No	_____
M. Aunt (s)	□ Yes □ No	_____	P. Aunt(s)	□ Yes □ No	_____
M. Uncles (s)	□ Yes □ No	_____	P. Uncle(s)	□ Yes □ No	_____

Please list any family member if there is a history of the following diseases:

Heart Disease _____ High blood pressure _____

Stroke _____ Diabetes _____

List other hereditary diseases: _____

SOCIAL HISTORY

Are you: □ Married □ Divorced □ Single □ Widowed

Number living in house _____

Education: □ Completed High school □ Completed College

Are you employed? □ Yes □ No Occupation (if retired former) _____

Have you used tobacco? □ Yes □ No

Circle type: Cigarettes Pipe Snuff Chew Cigars E-cigarettes

What age did you start? _____ How much? _____ Date stopped? _____

Have you ever used alcohol? □ Yes □ No If yes, types of products_____

What age did you start? _____ How much? _____ Date stopped? _____

Have you ever used illicit drugs? □ Yes □ No If yes, types of products_____

What age did you start? _____ How much? _____ Date stopped? _____

Do you exercise? _____ How often? _____

REVIEW OF SYSTEMS (Please check any item bothering you at this time)

□ Weight loss if yes, _____Pounds over_____months

□ Loss of appetite	□ Fever	□ Chills
□ Unusual fatigue	□ Sleep problems	□ Night Sweats
□ Glasses	□ Cataracts	□ Double vision
□ Glaucoma	□ Blurred vision	□ nose bleed
□ Decreased hearing	□ Ringing in ears	□ Dentures
□ Dental problems	□ Sinus problems	□ Cough
□ Sputum/phlegm	□ Cough up blood	□ Shortness of breath
□ Chest pain	□ Heart racing	□ Heart murmurs
□ Nausea	□ Vomiting	□ Difficulty swallowing
□ Diarrhea	□ constipation	□ Change in bowels
□ Abdominal pain	□ Blood in stools	□ vomiting blood
□ Frequent urination	□ Blood in urine	□ Pain/burning with urination
□ Urinate at night	How many times _____	□ Difficulty in urinating
□ Leg cramps	□ Joint pain	□ Joint stiffness
□ Joint swelling	□ Any pain Where? _____	
□ Dizziness	□ headaches	□ Numbness
□ Weakness	□ Seizures	□ change in personality
□ Depression	□ Nervousness/Anxiety	□ Increased thirst
□ Change in skin color	□ Rash	□ Bruise easily
□ Gum bleeding	□ Excessive bleeding	□ Any lump or mass

□ Blood transfusion if yes when_____

Please provide any details: _____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I acknowledge being informed about Surinder Vohra, MD PC (TLC Cancer Clinic) Notice of Privacy Practices

Patient's Name (print) _____

Signature _____

Date _____

If you are a legally Authorized Representative signing on behalf of this patient, please complete the following:

Print Representative's name: _____

□ Parent □ Spouse □ Guardian □ Power of Attorney □ Other: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ *Individual refused to sign*
□ *Communications barriers prohibited obtaining the acknowledgement*
□ *An emergency situation prevented us from obtaining acknowledgement*
□ *Other* _____

_____

Employee initials _____ *Date:* _____

Surinder Vohra, M.D., P.C.
TLC Cancer Clinic

FINANCIAL POLICY

Please remember that as your healthcare provider, our relationship is with you, not your insurance company. Please take the time to read your insurance policy carefully so that you will better know what will be covered and what your responsibilities are prior to services.

Insurance information must be updated at every visit. Our office will submit your bills directly to most insurance companies. For us to do this, we need to have your current information. Please have both primary and secondary insurance cards ready for review at each visit.

Although we participate with many insurance plans, we do not participate with all of them. If you belong to an HMO or PPO that requires you to go to a participating provider, it is your responsibility to assure that this occurs. Please obtain any necessary referral forms or authorizations that are needed before coming to our office. Without accurate insurance information or proper referrals, service may be delayed.

Co-payments and deductibles are due at the time services are rendered. This arrangement is part of your contract with your insurance company. We gladly accept cash, checks, or credit cards.

We know that sometimes financial problems occur. Payment plans may be arranged with the billing department directly; however, payments should be made in a timely manner. To contact the billing department, please call 845-7373 option #4.

If you have no insurance, payment is due at time of service unless previous arrangements have been made with our office. Any unpaid bill may be turned over to an outside collection agency after a reasonable attempt to obtain payment or other arrangements have been made. Any checks returned by the bank will be charged a **$25.00 return check fee**.
We will bill the insurance company for you and will wait a reasonable amount of time for payment directly from them. However, all charges are ultimately your responsibility from the date the service is rendered.

If you have a family spokesperson whom you would like us to discuss your financial policy, please inform us. This note will be made in your records, but we must have your consent.
Please feel free to contact us if you have any questions.

Signature _____ Date _____

SURINDER VOHRA MD PC
1600 Sixth Ave Suite 101, York, PA 17403

Permission to Release Diagnostic/Medical Information to another Person

Patient's Full Name: _____
(First) (MI) (Last)
Patient's Date of Birth:_____

If you would like us to release medical information or only specific medical information to family members or other individuals, please indicate below

I give Surinder Vohra M.D.'s office my permission to release <u>any</u> medical information to the following person (s):

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

I give Surinder Vohra M.D.'s office my permission to release <u>only the following specified</u> medical information to the following person (s):

Specified Information:_____

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

☐ YES ☐ NO Any information may be left on my answering machine/voice mail.
☐ YES ☐ NO Only the <u>specified information</u> may be left on my answering machine/voicemail.

Specified information: _____

Patient Signature: _____ **Date**: _____
If signed by other than patient, indicate relationship: _____
**Authorization is valid for one year from date signed unless I revoke this authorization or unless an earlier date is specified: _____.*