Gettysburg Cancer Center Hanover Cancer Center

Full Name:_____

Address:_____

Home PH:_____Work PH:_____Cell PH:_____

Contact Preference (please circle): Home Phone Work Phone Cell Phone Soc. Security #_____

Gender (please circle): Male / Female DOB:_____ Age:_____Email:_____

Primary Language: _____ Ethnicity (please circle): Hispanic or Non-Hispanic RACE:_____

Please indicate your highest level of education:_____

Marital Status (please circle): Single Married Partner Divorced Separated Widowed

Employer Name: _____ Occupation:_____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact PH: _____

Pharmacy Name: _____

Pharmacy PH: _____

Who can we thank for referring you today? _____

Who is your family Physician? _____ Office PH:_____

Medical History:

Do you have Diabetes? YES NO Do you have high blood pressure? YES NO

Have you had a heart attack? YES NO

Have you had exposure to any of the following (please circle if YES): Chemicals Asbestos Radiation

Have you ever smoked? YES NO

If so, for how long? _____

When did you quit? _____

Do you drink Alcohol? YES NO If yes, is your drinking mild, moderate or heavy? (Please Circle)

Work History: Are you retired? _____ From Where? _____

If you are currently working, where? _____

OVER

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL HEALTH INFORMATION

This authorization gives Satish A. Shah, M.D., P.C. permission to use and/or disclose health information about you.

Please read this entire document before signing.

My signature authorizes the disclosure of all protected information for the purpose of review and evaluation in regards to my treatment with Satish A. Shah, M.D., P.C; I expressly request that the designated record custodian of all covered entities under HIPAA identified on this form full and complete protected medical information including as specified in the following: medical records, meaning every page in my record including but not limited to office notes, face sheets, history & physical, consultation notes, inpatient/outpatient/emergency room reports/treatment and all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, discharge summaries, request for and reports of consultations, documents, correspondence, test results, billing records statements, pharmacy/prescription records, disability forms, questionnaires/histories, correspondence, photographs, videotapes, telephone message, and records received by other medical providers.

I authorize the release of health information as indicated above to the following representatives/physicians:

_____ _____

_____ _____

My signature or my appointed representative's signature certifies that my insurance information is correct to the full extent of my knowledge.

My signature or my appointed representative's signature certifies Satish A. Shah, M.D., P.C. to apply to my insurance for benefits on my behalf for covered services. I authorize the release to my insurers of medical and other coverage information necessary to process my claims. I request that my insurers pay directly to Satish A. Shah, M.D., and P.C. any benefits to which I may be entitled for their services.

My signature or my appointed representative's signature certifies **I understand that I am responsible for all charges whether or not paid by insurance; this includes Copayments, deductibles, Co-Insurance (if applicable), charges not covered by insurance, etc.** ***NOTE: If my insurance fails to pay for my services with Satish A. Shah M.D. P.C. I understand that I may be billed and expected to pay for services rendered.***

My signature or my appointed representative's signature certifies my consent to the use and disclosure of my health information for treatment, payment, and health care operations purposes as mandated under HIPAA and described as above.

_____ _____ Office Witness Initials _____

Print Patient's Full Name Date

_____

Patient or Personal Representative Signature

This Authorization shall expire 12 months from the date executed.