

ATLANTIC HEMATOLOGY ONCOLOGY ASSOCIATES, L.C.C.
1707 ATLANTIC AVENUE, MANASQUAN, NJ 08736
732-528-0760 FAX: 732-528-0764
WWW.ATLANTICHEMONC.COM

PATIENT NAME _____
BIRTH DATE _____ SS# _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # _____
SEX: MALE FEMALE

REFERRING PHYSICIAN _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # _____

PHARMACY NAME: _____
CITY _____
PHARMACY PHONE _____ FAX # _____

GUARANTOR'S NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # _____

EMPLOYER'S NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # _____

PRIMARY INSURANCE _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
POLICY # _____
GROUP # _____

INSURED'S NAME, IF DIFFERENT FROM PATIENT _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____

SS# OF INSURED (IF DIFFERENT FROM PATIENT) _____
DOB OF INSURED (IF DIFFERENT FROM PATIENT) _____
PATIENT'S RELATION TO THE INSURED: SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
POLICY # _____
GROUP # _____

INSURED'S NAME, IF DIFFERENT FROM PATIENT _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
SS# OF INSURED (IF DIFFERENT FROM PATIENT) _____
DOB OF INSURED (IF DIFFERENT FROM PATIENT) _____
PATIENT'S RELATION TO THE INSURED: SELF SPOUSE CHILD OTHER

Our office requires 24 hour notice of any change or cancellation of an appointment, failure to do so will result in a fee.

AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits to ATLANTIC HEMATOLOGY-ONCOLOGY ASSOCIATES, L.L.C. for service(s) described.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services (CMS) or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I authorize this office to furnish my insurance carriers with any information relevant to my claim, and to make direct payment when accepted.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to: MEDIGAP
INSURANCE: _____ any information needed to determine these benefits payable for related services.
HIC# _____

SIGNATURE _____ DATE _____

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PATIENT INFORMATION FORM

DATE:

Past Surgical History:

Marital Status:

- Single Married Divorced Widowed Has Significant Other

Living Arrangements:

- With Spouse Alone With Child(ren) With Family Nrsg. Home Other

Tobacco Use:

- Never Current Use Quit
 Year Discontinued smoking: _____
 Pack per year History: _____
 Type of Tobacco: _____

Alcohol Use:

- Never Currently uses Former Use
 Drinks per Day: _____ Drinks per Week: _____ Drinks per Month: _____
 Drinks per Year: _____ Stopped Alcohol Use (Year): _____

Illicit Drug Usage: (Have you ever used illicit drugs)

- Yes No
 Type: _____

Primary Occupation: _____

Secondary Occupation: _____

Occupational Exposure:

- No Occupational Exposure
- Type of Occupational Exposure: _____

Family History:

Family Cancer History:

- None Unknown Breast Ovarian
- Lung Pancreas Colon cancer (non-polyposis type)
- Multiple endocrine neoplasia type I
- Multiple endocrine neoplasia type II
- Medullary thyroid cancer
- Prostate
- Other: _____

Breast Cancer Family History:

- None
- Suspicion of BRCA-1 Suspicion of BRCA-2 Suspicion of P53

Family Medical History:

- No significant Significant
- Coronary Artery Disease Diabetes Hypertension Other

Health Maintenance: (List year of most recent)

- PAP Smear: _____ Mammogram: _____ Hysterectomy: _____
- Oophorectomy: _____ Colonoscopy: _____

Transfusion History:

- No transfusion history Transfused
- Blood Product type: _____ Units given: _____
- Transfusion reaction – None
- Transfusion reaction - Yes

Contraception:

- Does not Use Does Use
- Type used: _____ Years of use: _____
- Discontinued (year): _____

Menarche:

- Age of Menarche Cycle and days of Menses: _____
- # tampons used per day at peak: _____
- # Pads used per day at peak: _____
- Menopause (age): _____ No hot flashes Hot flashes

Birth History:

Number of times pregnant: _____

Age at first pregnancy: _____

Number of Live Births: _____

Stillborn

Abortions

Estrogen Use:

None

Yes

Estrogen Used: _____

Years of Estrogen use: _____ Year Estrogen was stopped

Allergies:

Medications:

Do you have a Living Will or a Do Not Resuscitate Order (DNR):

Yes

No

In not would you be interested in one?

Yes

No

FAMILY HISTORY QUESTIONNAIRE FOR CANCER

Name: _____
(Last, First, Middle Initial)

HEALTH HISTORY Please check boxes and tally the number of occurrences if there is personal and/or family history of any of the following conditions:

<u>Condition</u>	<u>Patient</u>	<u>Mother's Side</u>	<u>Father's Side</u>	<u># of Cases</u>
Breast Cancer (prior to age 60)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer for Male (any age)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer (any age)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometrial Cancer (prior to age 50)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer (prior to age 50)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Polyp(s) (under age 50 or more)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma (multiple family members)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer (any age)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eastern European Jewish Ancestry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ATLANTIC HEMATOLOGY-ONCOLOGY ASSOCIATES, L.L.C.

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered 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 form in its entirety before seeing the doctor.

IF WE ARE NOT PARTICIPATING WITH YOUR INSURANCE PLAN, FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, DEBIT CARDS/CREDIT CARDS.

REGARDING YOUR INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance policy. In the event that we do accept assignment of benefits, we require that you provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your responsibility. Please be aware that some and perhaps all of the services that are provided may be uncovered services, and not considered reasonable and necessary under the Medicare program and/or other medical insurance if doctor is non-participating with the insurance company. I authorize the insurance company to forward payment directly to the physician. Should payment be send directly to me, it is my responsibility to forward payment directly to physician. This office does not accept any and all Medicaid insurances. By signing this waiver you are aware that you are responsible.

I AUTHORIZE MY INSURANCE CARRIER TO FORWARD PAYMENT TO MY PHYSICIAN'S OFFICE.

A CURENT REFERRAL IS REQUIRED FOR OUR MANAGED CARE PATIENTS AT TIME OF SERVICE

Insurance plans, where we are a participating provider, co-payments are due prior to treatment. You will be billed for any deductible and co-insurance amounts. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Patients involved in worker's compensation or motor vehicle injuries must provide this office with an open claim number, name and address of insurance company, adjuster's name and phone number, in addition to your health insurance information. In the event that your claim is denied, you will be held responsible for all charges incurred. In accordance to New Jersey state laws, patients involved in motor vehicle accidents are responsible for their deductible and co-insurance amounts which may vary depending on your policy. Please refer to the above paragraph concerning your health insurance coverage for any outstanding balances.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patient are responsible for full payment according to their plan at the time of service.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, we reserve the right to charge at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THESE TERMS.

Please Print Name

Signature of patient or responsible party

Date

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- - Patient Contacts - -

In Case of emergency/family spokesperson: (This is the person the Doctor or office staff will speak with on your behalf regarding your healthcare. You are not required to list contacts if you don't wish to.)

Name: _____ Relationship: _____

Telephone # _____

You may also designate additional family members that our office may speak to regarding your healthcare if necessary.

Name: _____ Relationship: _____

Telephone # _____

Name: _____ Relationship: _____

Telephone # _____

This office will not discuss your protected health information with persons not on this list without your prior consent. You may revoke this authorization at any time.

Patient Signature

Date

ATLANTIC HEMATOLOGY ONCOLOGY ASSOCIATES, L.L.C.
1707 Atlantic Avenue, Manasquan, NJ 08736
732-528-0760 Fax: 732-528-0764

Arthur A. Topilow, M.D., F.A.C.P.
William A. Lerner, M.D., F.A.C.P.
Peter J. Mencil, M.D., F.A.C.P.
David B. Greenberg, M.D.
Michael J. Levitt, M.D.
Paula Canterino, M.S.N., R.N., A.P.N.-C
Tracey Ganley, M.S.N., R.N., A.P.N.-C

Date: _____

RECORDS RELEASE

To: _____

I hereby authorize you to release to: _____

Any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____

Patient's Name: _____ D.O.B.: _____

Address: _____

Patient's Signature

Witness

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DIRECTIONS

FROM SOUTH:

Take Parkway North to Exit 98. Follow signs for Route 34 South. Continue on 34 to the Sea Girt/Manasquan Exit. At the end of the off ramp turn right onto Atlantic Avenue. The office is on the right hand side about a mile up the road.

FROM NORTH:

Take Parkway South to Exit 98 and follow directions above.

FROM ROUTE 70 EAST:

Take 70 East to the end and continue through traffic light onto 35 North. At the Manasquan Circle go three quarters of the way around the circle and follow the sign that says Farmingdale. This will be Atlantic Avenue. The office is on the left hand side of the road right after the Siltan Swim School.

FROM ROUTE 35 SOUTH:

Take Route 35 South to the Manasquan Circle and follow the sign for Farmingdale. This will be Atlantic Avenue. The office is on the left hand side of the road right after the Siltan Swim School.