MRN : _____

Conway Hematology Oncology

350 Salem Rd. Suite 4 & 7
Conway, AR 72034
Phone: (501) 327-2995
Fax: (501) 327-2331

Patient Information – Please fill out completely.

Patient Name: _____
(First) (Middle Initial) (Last)

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Sex at Birth: ☐ Male / ☐ Female

Preferred Phone: (_____) _____–_____ Secondary Phone: (_____) _____–_____

E-Mail: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

Referring Physician/Facility: _____

Primary Care Provider (PCP): _____ PCP Phone #: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Please complete the following section (Check one):

- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown
- **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify
- **Race (Check all that apply):** ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American
  ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined to Specify
  ☐ Other: _____

****PROVIDE INSURANCE CARDS TO FRONT OFFICE STAFF****

Primary Insurance: _____ Policy ID: _____

Secondary Insurance: _____ Policy ID: _____

MEDICARE AND INSURANCE AUTHORIZATION ASSIGNMENT: I hereby authorize Sue Tsuda, M.D. to furnish medical information about me to the Health Care Financing Administration, other insurance carriers, or other payers (HMOs, PPOs, etc.) as needed to determine benefits/ benefits payable for needed services. I request payment of authorized Medicare or other benefits be assigned and payable to Dr. Tsuda for medical services furnished me or my dependents.

Signature: _____ **Date:** _____

Conway Hematology Oncology

OFFICE POLICIES & PROCEDURES NOTICE

Thank you for choosing *Conway Hematology Oncology*. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. In order for us to provide the best patient care we can, we have implemented the following policies and procedures. Please feel free to contact our office if you have any questions regarding our policies.

OFFICE HOURS

Our office is available Monday-Thursday 8:00am to 5:00pm, and Fridays 8:00am to 1:00pm (Suite 4 only). If you ever need to cancel or reschedule an appointment, refill a prescription, or have any questions, please call during regular business hours. **If you ever require immediate medical attention after hours, please contact the Medical Exchange at 501-329-1199** and you will be directed to the provider on call.

APPOINTMENTS

After seeing the provider, our office will contact you to schedule future appointments.

For provider appointments and CT scans, we will call you in advance to confirm the appointment. Please be sure to call us back to verify that you will be at your appointment.

If you are ever unsure about your next appointment, feel free to contact us or check with the front desk before you leave.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. This is how we best serve the needs of our patients.

If it is necessary to cancel your scheduled appointment, we ask that you call at least 1 business day in advance. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care.

TEST RESULTS

It is our office policy that we do not call patients with test results unless they are abnormal or critical. If you would like to know your results, please call our office and notify the front staff, and a nurse will call you back to give you those results.

However, you can view your lab results on our patient portal.

PATIENT PORTAL (ONTADA HEALTH)

Our patient portal, Ontada Health, is an easy-to-navigate, secure web portal designed especially for patients. By signing up for the portal, you can view your diagnosis, medications, clinical lab results, and office visits.

To sign up, provide your current e-mail address to our office. Within 24-48 hours after your first appointment, you will receive an e-mail with instructions for creating an account. If you cannot access your account or need to reset your password, you can contact our office for assistance.

CONTINUED →

Conway Hematology Oncology

INSURANCE & PAYMENT POLICY

Unless previous arrangements have been made, we ask that you pay your bill at the time of your visit. As a service to our patients, we will complete and file an insurance form so that reimbursement may be made in a timely manner. You will be responsible for any amount not covered by insurance including deductibles, copay, etc.

It is the responsibility of the patient to provide current, active insurance information at the time of service. As a curtesy to our patients, we do verify whether your policy on file is active at the time of your visit. However, it is ultimately your responsibility as the patient to remain in contact with your insurance company to ensure coverage for services done in our office.

We send out electronic billing statements once a month (if you would like yours via mail, please speak with our billing office). Patient balances can be paid in clinic or over the phone at 501-327-2995 Option 3.

I acknowledge that I have read (or had read to me) and fully understand the above information.

Patient Printed Name: _____

Signature: _____ Date: _____

MRN : _____

REVIEW OF SYSTEMS - Please mark all that apply.

GENERAL
- ☐ Weight Change
- ☐ Appetite Change
- ☐ Fever
- ☐ Chills
- ☐ Sweating
- ☐ Weakness/Easily Tired
- ☐ Change in Energy Level
- ☐ Pain

HEENT
- ☐ Headaches
- ☐ Fainting
- ☐ Seizures
- ☐ Hearing Problems
- ☐ Ear Infections
- ☐ Nose Bleeds
- ☐ Allergies
- ☐ Dentures
- ☐ Ulcers
- ☐ Hoarseness

RESPIRATORY
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Pleurisy (breathing pain)
- ☐ Chronic cough

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Murmurs
- ☐ Ankle Swelling
- ☐ Hypertension (high blood pressure)
- ☐ Shortness of breath while lying down
- ☐ Shortness of breath relieved by sitting up
- ☐ Wake up at night

GASTROINTESTINAL
- ☐ Difficulty Swallowing
- ☐ Nausea/Vomiting
- ☐ Vomiting Blood
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool

GENITOURINARY
- ☐ Get up at night to urinate
- ☐ Infection of Bladder or Kidney
- ☐ Difficulty Urinating
- ☐ Blood in Urine

MUSCULOSKELETAL
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Arthritis
- ☐ Back Problems
- ☐ Neck Pain
- ☐ Muscle or Leg Weakness

NEUROLOGICAL
- ☐ Dizziness
- ☐ Fainting
- ☐ Irritability
- ☐ Seizures
- ☐ Rashes
- ☐ Itching

LYMPH NODES
- ☐ Enlarged

Date of Last Chest X-Ray: _____

Date of Any Scans of Intestines, Stomach, or Colon: _____

Date of Any X-Rays of Kidneys: _____

Other Comments: _____

PAST SURGICAL

Please list all surgical procedures that you have had beginning with the first and ending with the most recent. If possible, also list surgeon and hospital.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

PAST MEDICAL

Please list any serious adult illnesses for which you take medications or for which you have been hospitalized. For example: heart attack, lung problems, arthritis, diabetes, tuberculosis, etc.

A. Problem: _____Year Diagnosed: _____
B. Problem: _____Year Diagnosed: _____
C. Problem: _____Year Diagnosed: _____
D. Problem: _____Year Diagnosed: _____
E. Problem: _____Year Diagnosed: _____
F. Problem: _____Year Diagnosed: _____
G. Problem: _____Year Diagnosed: _____

ALLERGIES

Please list all known drug and environmental allergies.

_____
_____
_____
_____

MEDICATIONS

Please list all medications you are currently taking.

_____
_____
_____
_____
_____
_____

OB/GYN – if applicable.

1) Number of Pregnancies: _____
2) Number of Live Births: _____
3) Number of Miscarriages: _____
4) Last Menstrual Period: _____
5) If Post-Menopausal: ☐ SURGICAL or ☐ NATURAL
6) Any Problems with Menstrual Cycle? _____

FAMILY HISTORY

Parents: Mother : ☐ LIVING ☐ DECEASED (Cause: _____)

Father : ☐ LIVING ☐ DECEASED (Cause: _____)

Siblings: How many living? _____ How many deceased? _____

Any family history of cancer or blood disorders? ☐ YES ☐ NO

If YES, please list relationship and disease:

_____

_____

_____

SOCIAL

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

☐ Other (please specify): _____

If Married, for how long? _____

Spouse's Name: _____ General Health: _____

Patient's Place of Employment: _____

Spouse's Place of Employment: _____

Number of Living Children: _____ How many live nearby? _____

Education Level (What is the highest level of school you have completed?):

☐ No schooling ☐ Some high school (no diploma) ☐ High school or equivalent

☐ Some college (no degree) ☐ Associate degree ☐ Bachelor's degree ☐ Master's degree

☐ Professional degree ☐ Doctorate degree ☐ Trade/technical/vocational training

Conway Hematology Oncology

HABITS

- Do you currently use, or have you used **tobacco**? (Please check the appropriate box.)

  ☐ **FORMER** ☐ **CURRENT** ☐ **NEVER**

  If so, what type? _____ How much? _____

  How long have you used the product? _____

- Do you currently use, or have you used a **vape**?

  ☐ **FORMER** ☐ **CURRENT** ☐ **NEVER**

  If so, how long?_____

- Do you currently use, or have you used **alcohol**? ☐ YES ☐ NO

  If YES, how often? _____

- Did you receive a **flu vaccination** this past year? ☐ YES ☐ NO

  In which month? _____ What type? _____

- Have you received a **covid vaccination**? ☐ YES ☐ NO

  When? _____ What brand (Moderna, Pfizer, J&J) ? _____

  Have you received the booster? ☐ YES ☐ NO

Conway Hematology Oncology

HIPAA/Protected Health Information (PHI) Disclosure

I hereby give my authorization for Conway Hematology Oncology to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Health Information is as follows:

> *Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.*

This protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

Individual's Name	**Phone Number**	**Relationship to You**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

I request this authorization expire on the following date: _____/_____/_____.

I may revoke it sooner in writing by contacting the Privacy Official Priscilla Klosky; I may also reach him/her by phone at 501-327-2995. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

_____

Patient Printed Name

_____ _____

Patient Signature (or Patient's Personal Representative) Date

Conway Hematology Oncology

General Authorization for Use or Disclosure of Protected Health Information

I HEREBY GIVE MY AUTHORIZATION to Conway Hematology/Oncology to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Health Information is as follows:

> *Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.*

This protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to other health care providers, group health plans, and business associates to provide for: my medical care, treatment, and evaluation; the payment of my medical care, treatment, and evaluation; and to provide information for utilization and quality care purposes.

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

This authorization shall remain in effect until I revoke it in writing by contacting the Privacy Official, Priscilla Klosky; I may also reach her by phone at 501-327-2995. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

I understand I have the right to request in writing to inspect and copy my Protected Health Information. There are a few exceptions to this rule. My Health Care provider must approve or deny my request within 30 days and, in the case of denial, provide me an explanation of the reason. My Health Care Provider may charge a reasonable fee for copying, preparation, and postage (if mailed to me) which must be prepaid.

_____

Patient Printed Name

_____ _____

Patient Signature (or Patient's Personal Representative) Date