BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

Hematology **Date:**_____

Patient Registration

Diagnosis:_____

Name: _____ **I prefer to be called:** _____
Last First MI

Date of Birth: _____ **Social Security Number:** _____

Address: _____ **City:**_____ **State:**_____ **Zip**_____

Home # (_____) _____ **Cell #** (_____) _____ **Work #** (_____)_____

Email Address_____

Which numbers may we use? ☐ Home ☐ Cell ☐ Work May we leave a message? ☐ Yes ☐ No

Check Appropriate Box:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Retired ☐ Disabled Occupation: _____ Employer: _____

Have you served in the military ☐ No ☐ Yes Where _____ When _____

Spouse's Name: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Race: □ Caucasian □ American Indian □ Asian **Ethnicity:** □ Hispanic □ Non-Hispanic
□ African American □ Native Hawaiian □ Alaskan
□ Unknown □ Other _____ □ Decline to Answer

Advance directives: Do you have an Advanced Directive □ Yes □ No

Preferred Main Language: □ English □ Spanish □ Arabic □ Other_____

Whom may we thank for referring you? _____

Doctor Information

Family/Primary Physician _____ **Phone:** _____

Address _____ **Fax :**_____

Referring Physician: _____ **Phone:** _____

Address _____ **Fax :**_____

Insurance Information

Primary Insurance

Name of Insured _____DOB_____SSN# _____

Relationship to Patient: Self Spouse Dependent Other

Insurance Company_____ Grp #_____ ID#_____

Secondary Insurance

Name of Insured _____DOB_____SSN# _____

Relationship to Patient: Self Spouse Dependent Other

Insurance Company_____ Grp #_____ ID#_____

New Patient History

Current Problem

Current Please describe briefly how your current problem started. What were your symptoms?

_____

_____

_____

_____

Cancer History

Type of your cancer: _____ Date of Diagnosis: _____

If you have had previous treatment, please include type of treatment below:

Treatment with surgery: ☐ Yes ☐ No When & Where: _____

Radiation Therapy: ☐ Yes ☐ No When & Where: _____

Chemotherapy: ☐ Yes ☐ No When & Where: _____

Medical History

Please check if you have had any of the following medical conditions

☐ Anemia	☐ Gallbladder Disease	☐ Pacemaker / Defibrillator
☐ Arthritis	☐ Acid Reflux	☐ Anxiety
☐ Asthma	☐ Glaucoma	☐ Seizures
☐ Bleeding Disorders	☐ Heart Disease	☐ Stomach Ulcers
☐ Breast Disease	☐ Hepatitis	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disease
☐ COPD/Emphysema	☐ High Cholesterol	☐ Tuberculosis
☐ Depression	☐ HIV/AIDS	☐ Heart Attack
☐ Diabetes	☐ Kidney Disease	☐ Lupus/Scleroderma

Additional Comments: _____

Surgical History

Please list all surgeries, major diseases, illnesses, or conditions for which you have been hospitalized:

	Surgeries or hospitalizations	Date	Where
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

Social History	
Religious Belief	☐Catholic ☐Jewish ☐Protestant ☐Muslim ☐Other: _____
Have you been exposed to:	☐Asbestos ☐Chronic Fumes ☐Chronic Dust ☐Radiation ☐Toxic Chemicals ☐Others: _____
Alcohol Use	How many alcoholic beverages do you drink per week:_____
Smoking Status	❑ Never smoked ❑ Current Smoker: How many years have you smoked? _____ How many cigarettes do you smoke a day? _____ ❑ Quit When did you quit? _____ How many years did you smoke? _____ How many cigarettes did you smoke per day? _____ □ Cigarettes □ Marijuana □ Cigars or pipes □ Chewing tobacco ☐Hookah □ Other_____

Females History

Menstrual History

Age when menstruation began? _____

Are you still having monthly periods? □ Yes □ No

Is your menstruation slight, moderate, heavy, or irregular? _____

Are you presently using an IUD or birth control pills? _____

Date of your last menstrual cycle: _____

Is there any possibility you could be pregnant at this time? □ Yes □ No

Menopause

If you are no longer having a menstrual cycle, at what age did your monthly periods stop? _____

Did your menopause occur as a result of: □ Natural □ Surgery □ Following chemotherapy?

Do you experience hot flashes? □ Yes □ No

Any previous history of hormone use

Contraceptive Hormone use: □ No □ If yes, for how many years: _____

Post Menopause Hormones: □ No □ If yes, for how many years: _____

Pregnancies

Number of pregnancies: _____

Number of children born alive: _____

What was your age at your first pregnancy? _____

Current Medication List

List all medications you are taking, including vitamins, nonprescription drugs, and herbal supplements.

Bring all Medications to your first appointment

Drug	Amount/Dose	Frequency

Retail Pharmacy Name: _____ Phone# (_____) _____-_____

Pharmacy Address: _____ Fax #: (_____) _____-_____

Mail Order Pharmacy Name: _____ Phone# (_____) _____-_____

Do you have prescription coverage? □ Yes □ No

Allergy Information

Latex Allergy □ Yes □ No Iodine Allergy □ Yes □ No

OTHER ALLERGY INFORMATION	REACTION

FAMILY HISTORY

Include blood relatives only. Do not include anyone adopted, foster, step-relatives, or those related by marriage. List any current ages or age at time of death.

Relative	Age	Alive Y/N?	Had Cancer Y/N?	If yes, What type?	Died of Cancer Y/N?	Other Medical Problems Y/N?	If yes, list medical problem (heart disease, diabetes, etc.)
Mother							
Father							
Mother's Mother							
Mother's Father							
Father's Mother							
Father's Father							
Daughter 1							
Daughter 2							
Daughter 3							
Daughter 4							
Son 1							
Son 2							
Son 3							
Son 4							
Sister							
Sister							
Sister							
Brother							
Brother							
Brother							
Other							
Other							

Name:_____ Date:_____

Authorized Patient Communication List

Patient or authorized person: I authorize any physician, hospital, or medical care facility to provide all information regarding my medical history and treatment to the Karmanos Cancer Institute. Photocopies of this form may be considered to be as valid as the original.

(Optional) Patient or authorized person: I authorize Karmanos Cancer Institute to discuss my medical condition and/or release medical information the following people (i.e. family members):

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Name_____ Relationship_____ DOB_____ Phone_____

Patient Signature: _____ Date:_____

McLAREN HEALTHCARE
Authorization to Release Information

Patient Name _____ Birthdate _____ Medical Record Number _____

Address _____

Phone Number _____ Maiden/Other Names _____

I authorize MCLAREN/KARMANOS ONCOLOGY (name)
5680 BOW POINTE DR, SUTE 202 (address)
CLARKSTON MI 48346 (city,state,zip)
248-922-6650/248-922-6655 (telephone/fax)

to release to _____ (name)
_____ (address)
_____ (city, state, zip)
_____ (telephone/fax)
_____ (email address)

Specific type of information to be disclosed: **Date(s) of Service:** _____

- ☐ History and Physical
- ☐ Operative Report
- ☐ Physician's Notes
- ☐ Consultation Reports
- ☐ Therapy Notes
- ☐ Discharge Summary
- ☐ Laboratory Results
- ☐ Billing Records
- ☐ Home Care Records
- ☐ Diagnostic Imaging (e.g., X-Rays) reports from (date) _____
- ☐ Diagnostic Imaging (e.g., X-Rays) films from (date) _____
- ☐ Other _____

Sensitive information to be disclosed: **Date(s) of Service:** _____

- ☐ Behavioral and Mental Health Service Information (excluding Psychotherapy Notes)
- ☐ Referrals and treatment for alcohol and substance use disorder
- ☐ Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

☐ **Consent to release Entire Medical Record, for dates of service listed, including all information noted above:**

Date(s) of Service: _____

_____
Initials **Date**

Please continue to the otherside of this form for Acknowledgements and signatures.

By signing this form I understand:

1. That I need not sign this form in order to ensure treatment, payment for treatment or enrollment or eligibility for health benefits.

2. My health information may be shared electronically.

3. The sharing of my health information will follow state and federal laws and regulations.

4. This form does not give my consent to share psychotherapy notes as defined by federal law.

5. I can withdraw my consent at any time; however, any information shared with or in reliance upon my consent cannot be taken back. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization is in effect for no more than 60 days after date it was signed unless otherwise specified. Upon conclusion of that time period, this authorization is automatically revoked and no further disclosure of the patient's information is permitted.

6. I should tell all agencies and people listed on this form when I withdraw my consent.

7. I can have a copy of this form.

8. That unless otherwise indicated or specified here, a request for disclosure or release of my "Entire Medical Record" or health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

9. That any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

10. By signing this form, I confirm that I understand the information and any questions have been answered about this form.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, State Relationship to Patient

_____ _____

Signature of Witness Date

PT.

MR.#/P.M.