



DANIEL PATTERSON
MD (Hons), PhD, MRCP (UK), FACP
Board Certified Hematology
Board Certified Oncology
Board Certified Internal Medicine
Diplomat Stem Cell Transplantation

Please Print Clearly and Answer Each Statement

Today's Date: _____

Patient Name: _____ Male Female

Date of Birth: _____ Age: _____ SS#: _____ - _____ - _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Home Ph#: (_____) - _____ - _____ Cell #: (_____) - _____ - _____

You were referred By: Dr. _____ Your PCP is: Dr. _____

Please Check One

Marital Status: Married Single Divorced Widowed Other: _____

Work Status: Retired Employed Current/Past Occupation: _____

Race: African-American Caucasian Hispanic Other: _____

Ethnicity: Non-Hispanic/Non-Latino Hispanic/Latino Other/Undetermined

Insurance Primary: _____ ID# _____

Insurance Secondary: _____ ID# _____

****I certify that the insurance information that I provided is true**

and correct to the best of my knowledge**

Do you have the following: Living Will/Advance Directives DNR Power of Attorney

Please list at least two persons who may be contacted in an emergency:

1. Name: _____ Ph#: _____

2. Name: _____ Ph#: _____

Is there an email address you would like to provide our office for online records: YES NO

Patient Signature: _____ Date: _____



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Financial Policy

We accept Medicare assignment. We will file claims for secondary insurance as a courtesy to you if all the accurate information is provided to us. We will only file two (2) insurances for you; if you have a third insurance policy you must file the claim yourself. All co-payments, deductibles, and balances are due at the time services are rendered unless prior arrangements have been made by our billing management. I understand that should my insurance company send payment to me, I will forward the payment to the provider within 48 hrs. In the event that your insurance coverage changes, it is your responsibility to notify us immediately of the changes, otherwise you will be responsible for the payment services denied by your insurance plan. Payment arrangements can be made with our billing management for services rendered. However that is a contract you will enter into with us at that time. Dishonored checks will be returned to patients only after acceptable payment is made. All fees related to the returned check will be assessed to the patient with the expectation of payment in full within 30days. After that time this office will refer the matter to small claims court or to our practice attorney.

Balances on your account are due immediately and prior to your next visit to the office. Failure to pay your balance in a timely manner may results in a cancelled appointment. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials. **I understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.**

I authorize the provider and his staff to submit and sign any copay assistant or drug assistant application on my behalf.

Prescription Policy

We do require 48-72 hours notice for prescription refill requests. Please request new prescriptions or refill at appointments, when possible. Please try to call for a refill a few days prior to taking your last dose to give the pharmacy and our office a chance to order your medication. By signing below **you are providing consent for our office to import your current prescription list from your pharmacy to allow accuracy.**

Please call one of our medical assistants during office hours for questions or requests for prescription refills, as we must review your medical chart. Please have the drug you need refilled, the dosage, how often you take it and your pharmacy's phone number available. We discourage prescribing new medications over the telephone, as an accurate diagnosis is usually possible only with an office visit.

Telephone Calls

When calling with a problem or question, describe the situation in detail to our staff. This will help the doctors determine the nature of the problem and respond quickly and accurately to your request. A staff member will return your call as soon as possible after the provider reviews your information.

Unless the situation is very urgent or an emergency, calls will usually be returned during lunch or after the last patient appointment of the day. Please make sure you leave a number where you can be reached at these times.

Appointments Policy

If you cannot keep your appointment, please give us at least 24 hours notice. Additionally, if you will be unavoidably late for your appointment, please call us to let us know.

Patient's Signature: _____

Date: _____

Please Print Patient Name: _____



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Patient Consent for Use and Disclosure of Protected Health Information

With my consent Bethel Blood and Cancer Center, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Bethel Blood and Cancer Center, P.A. Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Bethel Blood and Cancer Center, P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bethel Blood and Cancer Center, P.A.'s Privacy Officer at 3256 S Pine Ave, Suite 303, Ocala, Florida 34471.

With My consent, Bethel Blood and Cancer Center, P.A. may call or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others. Also, With My consent, Bethel Blood and Cancer Center, P.A. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Bethel Blood and Cancer Center's use/disclosure of my PHI to carry out TPO. If I do not sign this consent, the practice may decline to provide treatment to me. I may revoke my consent in writing except to the extent that the practice has already made disclosures upon prior consent.

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Bethel Blood and Cancer Center, P.A. is authorized by me to use or disclose my PHI for treatment, payment, or other health care operations. I specifically authorize any current employee or owner of Bethel Blood and Cancer Center, P.A., or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used/disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so in writing, at any time.

Description of the information to be used/disclosed (check all that apply)

- The patient's entire medical record
- Medical Data/Information as related to:
 - Specific condition(s): _____
 - Specific professional service(s): _____
 - Specific Medication(s): _____
- Other: _____

Name of person(s) that my PHI may be disclosed to (spouse, children, family members, friends, etc.-must specify by name)

I understand that I have the right to revoke this authorization at any time. In order for the revocation to be effective, Bethel Blood and Cancer Center, P.A., must receive the revocation in writing. I also understand that by signing below that I am giving Bethel Blood and Cancer Center, P.A. consent for my treatment and that I agree to all the terms listed above.

Patient's Signature: _____ Date: _____

Please Print Patient Name: _____



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Medical Records Release

Patient Name: _____ DOB: _____

Date Range: _____

I _____, hereby authorize the release of a copy of my medical records in accordance with your policies to Bethel Blood and Cancer Center, PA.

The Release of information regarding psychiatric, drug and alcohol abuse treatment or of any information concerning AIDS, Immunodeficiency Virus Infection and the performance of any test, counseling and the results of treatments thereof are hereby authorized. I understand that my records have a privileged and confidential status. I am waiving that status for the purpose stated.

I understand that this consent is revocable only in writing and in a timely manner. I agree to hold all cost, liability and damages of any nature resulting directly or indirectly from release of my medical records.

PROHIBITION ON REDISCLOSURE BY REQUESTOR: This information has been disclosed to you for records whose confidentiality is protected. You cannot make any further disclosures without the specific written consent of the patient. A general authorization is not sufficient for this purpose.

USE (check one): Continued Medical Care Attorney
 Insurance Personal

Documents needed:
 Pertinent Info Entire Medical Records Other: _____

I acknowledge that I have read this authorization and fully understand its contents.

Patients Signature: _____ Date: _____

| | | |
|---|---|--|
| <p><u>Please Fax the requested records to the following location :</u></p> | <p><input type="checkbox"/> <u>Ocala</u> 3256 S Pine Ave Suite # 303 Ocala, FL 34471 Ph: 352-512-0688 Fx: 352-512-0689</p> | <p><input type="checkbox"/> <u>TimberOaks</u> 11660 SW 97TH Terrace Suite # 201 Ocala, FL34481 Ph: 352-291-9376 Fx: 352-291-9377</p> |
|---|---|--|

Name: _____ DOB: _____ Date: _____

Primary Care: _____ Pharmacy: _____

CURRENT /NEW MEDICAL HISTORY

| <u>CONSTITUTIONAL:</u> | <u>YES</u> | <u>NO</u> | <u>GASTROINTESTINAL</u> | <u>YES</u> | <u>NO</u> | <u>NEUROLOGICAL:</u> | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|------------------------------|-----------------------------|
| Change in appetite | <input type="checkbox"/> | <input type="checkbox"/> | Nausea | <input type="checkbox"/> | <input type="checkbox"/> | Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Neuropathy | <input type="checkbox"/> | <input type="checkbox"/> |
| General Weakness | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Focal Weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Fever <input type="checkbox"/> Chills | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Night Sweats <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Tremor | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Change <input type="checkbox"/> Gain <input type="checkbox"/> Loss | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Altered Consciousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Altered Taste | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>HEMATOLOGIC</u> | <u>YES</u> | <u>NO</u> | Blood in Stools | <input type="checkbox"/> | <input type="checkbox"/> | Speech Impairment | <input type="checkbox"/> | <input type="checkbox"/> |
| Easy bruising | <input type="checkbox"/> | <input type="checkbox"/> | Dark Stools | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | <u>GENITOURINARY</u> | <u>YES</u> | <u>NO</u> | <u>PSYCHIATRIC</u> | <u>YES</u> | <u>NO</u> |
| <u>LYMPHATICS</u> | | | Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> | <input type="checkbox"/> |
| Enlarged lymph nodes | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Night Urination | <input type="checkbox"/> | <input type="checkbox"/> | Stress | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>EYES:</u> | <u>YES</u> | <u>NO</u> | Hesitancy | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | Urgency | <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | Incontinence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Confusion <input type="checkbox"/> Hallucinations | | <input type="checkbox"/> |
| Watery/Dry Eyes | <input type="checkbox"/> | <input type="checkbox"/> | Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> | <u>ENDOCRINE</u> | <u>YES</u> | <u>NO</u> |
| <u>EAR/NOSE/THROAT:</u> | <u>YES</u> | <u>NO</u> | Frequent Urination | <input type="checkbox"/> | <input type="checkbox"/> | Intolerance <input type="checkbox"/> Cold <input type="checkbox"/> Heat | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <u>MUSCULOSKELETAL</u> | <u>YES</u> | <u>NO</u> | Excessive Sweating | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringling in Ears | <input type="checkbox"/> | <input type="checkbox"/> | Bone Pain | <input type="checkbox"/> | <input type="checkbox"/> | Increased Thirst | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Tenderness | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> | <u>Medications Stopped in Past Month</u> | | |
| Mouth Sores | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Dry Mouth | <input type="checkbox"/> | <input type="checkbox"/> | Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <u>CARDIOVASCLUAR</u> | <u>YES</u> | <u>NO</u> | Joint Swelling | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Limited Range of Motion | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | <u>INTEGUMENTARY</u> | <u>YES</u> | <u>NO</u> | | | |
| <input type="checkbox"/> Ankle <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> | <input type="checkbox"/> | Rash | <input type="checkbox"/> | <input type="checkbox"/> | Allergic to Latex | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <u>RESPIRATORY:</u> | <u>YES</u> | <u>NO</u> | Itching | <input type="checkbox"/> | <input type="checkbox"/> | Covid Vaccine: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | Skin Lesions | <input type="checkbox"/> | <input type="checkbox"/> | Booster: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cough <input type="checkbox"/> Wet <input type="checkbox"/> Dry | <input type="checkbox"/> | <input type="checkbox"/> | Dry Skin | <input type="checkbox"/> | <input type="checkbox"/> | Flu Shot | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | | | | Pneumonia Shot | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Review of Systems: Please check each item "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

| | | | | | | | | | |
|--------------------------|--------------------------|--|--|--------------------------------|--|------------|--|--|--|
| YES | NO | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever smoked? If YES, # of packs a day | | | | # of years | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you still smoking? | | If stopped, when did you quit? | | | | | |

Past Family History: PLEASE COMPLETE THE FOLLOWING TABLE

| | Age, If Alive | Health Problems | Age at Death | Cause of Death |
|-------------|---------------|-----------------|--------------|----------------|
| Mother | | | | |
| Father | | | | |
| Siblings | | | | |
| Siblings | | | | |
| Grandfather | | | | |
| Grandmother | | | | |

| | | | | | | | | |
|----------------------|--------------------------|-------------|--------------------------|--------|--------------------------|-----------|--------------------------|-------|
| Marital Status: | <input type="checkbox"/> | Married | <input type="checkbox"/> | Single | <input type="checkbox"/> | Divorced | <input type="checkbox"/> | Widow |
| Living Arrangements: | <input type="checkbox"/> | Spouse | <input type="checkbox"/> | Alone | <input type="checkbox"/> | Children | <input type="checkbox"/> | Other |
| Children: | <input type="checkbox"/> | No Children | | | <input type="checkbox"/> | Children: | | |

| | | | | | | | |
|--------------------------|--------------------------|---|------|-------|---------|------|--|
| YES | NO | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol? If yes, please list type and quantity | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use recreational drugs? What type: | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise? | Type | Miles | x daily | wkly | |

| | | | | |
|-----------------------------|--------------------------|-----|--------------------------|----|
| HIV RISK OR POSITIVE | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
|-----------------------------|--------------------------|-----|--------------------------|----|

WOMEN ONLY

| | | | | | |
|---|--------------------------|------------------------------|--------------------------|--------------------------|--------------|
| How old were you when your menstrual cycle began? | | | | | |
| What age for Menopause? | | | | | |
| Age at first pregnancy: | | | | <input type="checkbox"/> | No pregnancy |
| # of Live Births | | # of Stillborn / Miscarriage | | # of Abortions | |
| Menstrual cramps: | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | |
| Hormone Replacement? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | # of Years |
| Contraception: | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | |
| | Type: | Years of use: | | Year Stopped: | |

Health Maintenance

| | | | |
|---------------|--------------------------|-------|---------------------|
| Colonoscopy: | <input type="checkbox"/> | Never | Date of Last: _____ |
| EGD: | <input type="checkbox"/> | Never | Date of Last: _____ |
| Mammogram: | <input type="checkbox"/> | Never | Date of Last: _____ |
| Bone Density: | <input type="checkbox"/> | Never | Date of Last: _____ |

WOMEN ONLY

| | | | |
|-----------|--------------------------|-------|---------------------|
| Pap Smear | <input type="checkbox"/> | Never | Date of Last: _____ |
|-----------|--------------------------|-------|---------------------|

MEN ONLY

| | | | |
|----------------|--------------------------|-------|---------------------|
| PSA | <input type="checkbox"/> | Never | Date of Last: _____ |
| Prostate Exam: | <input type="checkbox"/> | Never | Date of Last: _____ |

| | |
|-------------|----------------------|
| Pain Level: | 1 2 3 4 5 6 7 8 9 10 |
| Location: | _____ |