Bethel Cancer Center Blood
Bringing Blessings & Compassionate Care
www.BethelCancerCenter.com

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 understand that I am giving authorization for the provider to submit any medical claims for payment, and I will follow the contract, I signed with my insurance company for copays, deductibles, and out of pocket expenses. 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.

Consent for Testing and Treatment

Due to the nature of our practice and specialty, it may be necessary to send samples to outside facilities for addition testing, or refer you to other providers or facilities. The purpose of the testing will allow the physician to further care for you and make informative medical decisions about your care. Testing included but not limited to bloodwork, radiology, DNA testing, pathology test, bone marrow biopsy, etc. ***By signing, I consent to have any necessary and all testing to be performed to make informative medical decisions for my care. By signing, I consent for treatment that includes but not limited to injections and IV therapy, that the physician and I deem medically necessary***

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 singing 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:** _____

Please Fax the requested records to the following location :	☐ **Ocala** 3256 S Pine Ave Suite # 303 Ocala, FL 34471 Ph: 352-512-0688 Fx: 352-512-0689	☐ **TimberOaks** 11660 SW 97TH Terrace Suite # 201 Ocala, FL34481 Ph: 352-291-9376 Fx: 352-291-9377

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Name: _____ **DOB:** _____ **Date:** _____

Primary Care: _____ **Pharmacy:** _____

CURRENT /NEW MEDICAL HISTORY

CONSTITUTIONAL:	***YES***	***NO***
Change in appetite	☐	☐
Fatigue	☐	☐
General Weakness	☐	☐
☐Fever ☐ Chills	☐	☐
☐Night Sweats ☐ Hot Flashes	☐	☐
Weight Change☐ Gain ☐ Loss	☐	☐
Altered Taste	☐	☐

HEMATOLOGIC	***YES***	***NO***
Easy bruising	☐	☐
Excessive Bleeding	☐	☐

LYMPHATICS		
Enlarged lymph nodes	☐	☐

EYES:	***YES***	***NO***
Blurred Vision	☐	☐
Double Vision	☐	☐
Watery/Dry Eyes	☐	☐

EAR/NOSE/THROAT:	***YES***	***NO***
Hearing Loss	☐	☐
Ringing in Ears	☐	☐
Sinus Tenderness	☐	☐
Mouth Sores	☐	☐
Dry Mouth	☐	☐

CARDIOVASCLUAR	***YES***	***NO***
Chest Pain	☐	☐
Palpitations	☐	☐
☐Ankle ☐Leg Swelling	☐	☐

RESPIRATORY:	***YES***	***NO***
Shortness of Breath	☐	☐
Cough ☐Wet ☐Dry	☐	☐
Coughing up blood	☐	☐

GASTROINTESTINAL	***YES***	***NO***
Nausea	☐	☐
Vomiting	☐	☐
Difficulty Swallowing	☐	☐
Heartburn	☐	☐
Abdominal Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in Stools	☐	☐
Dark Stools	☐	☐

GENITOURINARY	***YES***	***NO***
Painful Urination	☐	☐
Frequent Night Urination	☐	☐
Hesitancy	☐	☐
Urgency	☐	☐
Incontinence	☐	☐
Blood in Urine	☐	☐
Frequent Urination	☐	☐

MUSCULOSKELETAL	***YES***	***NO***
Bone Pain	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Back Pain	☐	☐
Joint Swelling	☐	☐
Limited Range of Motion	☐	☐

INTEGUMENTARY	***YES***	***NO***
Rash	☐	☐
Itching	☐	☐
Skin Lesions	☐	☐
Dry Skin	☐	☐

NEUROLOGICAL:	***YES***	***NO***
Headache	☐	☐
Neuropathy	☐	☐
Focal Weakness	☐	☐
Paralysis	☐	☐
Tremor	☐	☐
Altered Consciousness	☐	☐
Seizures	☐	☐
Speech Impairment	☐	☐
Dizziness	☐	☐

PSYCHIATRIC	***YES***	***NO***
Nervousness	☐	☐
Stress	☐	☐
Depression	☐	☐
Memory Loss	☐	☐
☐ Confusion ☐ Hallucinations		☐

ENDOCRINE	***YES***	***NO***
Intolerance ☐Cold ☐Heat	☐	☐
Excessive Sweating	☐	☐
Increased Thirst	☐	☐

Medications Stopped in Past Month

Allergic to Latex	☐YES	☐NO
Covid Vaccine:	☐YES	☐NO
Booster: ☐YES ☐NO		
Flu Shot	☐YES	☐NO
Pneumonia Shot	☐YES	☐NO

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

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Are you allergic to any medications?	( ) YES	( ) NO
List what medication(s)		

Past Patient History

PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

CONDITION	YES	NO	CONDITION	YES	NO
INFECTIOUS DISEASES			**ENDOCRINE**		
Hepatitis	☐	☐	Diabetes	☐	☐
HIV / AIDS	☐	☐	Thyroid Problems	☐	☐
Polio	☐	☐	**GASTROINTESTINAL**		
Rheumatic Fever	☐	☐	Stomach Ulcer	☐	☐
Tuberculosis	☐	☐	Gallstones	☐	☐
CARDIOVASCULAR			Liver Disease	☐	☐
High Cholesterol	☐	☐	**RENAL / GENITOURINARY**		
High Blood Pressure	☐	☐	Kidney Disease	☐	☐
Birth Defect of Heart	☐	☐	Kidney Stones	☐	☐
Heart Murmur	☐	☐	Prostate Problems	☐	☐
Pericarditis	☐	☐	Urinary Tract Infections	☐	☐
Heart Attack	☐	☐	**MUSCULOSKELETAL**		
Previous Stent or Angioplasty	☐	☐	Gout	☐	☐
Irregular Heart Beats	☐	☐	Arthritis	☐	☐
Peripheral Vascular Disease	☐	☐	Back Pain	☐	☐
PULMONARY / NEUROLOGICAL			Herniated Disc	☐	☐
Lung Disease	☐	☐	**HEMATOLOGY / ONCOLOGY**		
Prior Pneumonia	☐	☐	Anemia	☐	☐
Exposure Hazardous Agent	☐	☐	Cancer -**TYPE**	☐	☐
Stroke / TIA	☐	☐	Blood Clots	☐	☐
Migraines	☐	☐	Blood Transfusion Date:	☐	☐
Seizure Disorder	☐	☐	Platlet Transfusion Date:	☐	☐

Past Patient History: Please list below ALL your past Operations, Hospitalizations, Illness / Injuries

PLEASE BE SPECIFIC AS TO REASONS AND DATES

Please List All Past Operations / Hospitalizations with reason and dates	Please List All Illnesses / Injuries with dates

Please List Current Prescription Medications and / or Over – the – Counter Medications and Dosages

Medication Name	Dose	# of times a day	Medication Name	Dose	# of times a day

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YES	NO								
☐	☐	Have you ever smoked? If YES, # of packs a day						# of years	
☐	☐	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:	☐	Married	☐	Single	☐	Divorced	☐	Widow
Living Arrangements:	☐	Spouse	☐	Alone	☐	Children	☐	Other
Children:	☐	No Children			☐	Children:		

YES	NO								
☐	☐	Do you drink alcohol? If yes, please list type and quantity							
☐	☐	Do you use recreational drugs? What type:							
☐	☐	Do you exercise?	Type		Miles		x daily wkly		

HIV RISK OR POSITIVE		☐	YES	☐	NO			

WOMEN ONLY

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

Health Maintenance

Colonoscopy:	☐	Never	Date of Last: _____
EGD:	☐	Never	Date of Last: _____
Mammogram:	☐	Never	Date of Last: _____
Bone Density:	☐	Never	Date of Last: _____

WOMEN ONLY

Pap Smear	☐	Never	Date of Last: _____

MEN ONLY

PSA	☐	Never	Date of Last: _____
Prostate Exam:	☐	Never	Date of Last: _____

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