HOAA
HEMATOLOGY & ONCOLOGY
ASSOCIATES OF ALABAMA, LLC

Patient Name:_____ Date of Birth:_____

Home phone:_____ Cell phone: _____

Email:_____

Allergies:

Drug	**Describe reaction**

Medications taking at home:

Medication	Dosage	How often	**Medication**	Dosage	How often

Current Healthcare Providers:

Name of Primary Care Physician:_____

Name of Physician:_____Specialty:_____

Patient Name:_____DOB:_____

Name of Physician:_____Specialty:_____

Name of Physician:_____Specialty:_____

Pharmacy Information:

Pharmacy:_____**Phone number**:_____

Address:_____

Social History:

Have you ever used tobacco?_____Packs/day?____How many years?____Have you quit?/When?_____

Have you ever used alcohol?_____Please describe how much and how often?_____

What is your current/prior job(s)/position?_____

Have you ever had contact with chemicals or other toxins such as asbestos? If so, please describe:
_____

Marital Status (Circle Applicable): Married Single Divorced Widowed

Biological children? How many?_____Boys?___Girls?___Adopted children? Boys?_____Girls?_____

Advanced Directive (Circle) Yes/No

Living will (Circle) Yes/No

DNR (Circle) Yes/No

Review of Symptoms (please mark "yes" or "no". If yes, please describe)

Have you experienced any of these symptoms recently?

Symptoms	**Yes**	**No**	**Description**
Weight loss			
Fever			
Fatigue			
Night sweats			
Headaches			
Visual Disturbances			

Hearing Disturbances			
Recent Cough			
Shortness of Breath			
Coughing up blood			
Appetite Changes			
Nausea/Vomiting			
Back Pain			
Loss of Consciousness			
Problems with blood			
Bowel Pattern Changes			
Urinary Problems			
Kidney Stones			

Please check any of the diseases listed below that you have been diagnosed with:

Hypothyroidism		Hyperlipidemia		Diabetes		Gastroesophageal Reflux disease	
Myocardial Infarction		Peripheral Vascular Disease		Congestive Heart Failure		Ulcerative Colitis	
DVT		Pulmonary Embolism		Osteoporosis		CVA	
Rheumatoid Arthritis		Osteoarthritis		Chronic Sinusitis		Kidney Stones	
Polymyalgia Rheumatica		Lumbar Disk Disease		Lowe GI bleed			
COPD		Asthma		Hepatitis			
Peptic Ulceration		Upper GI bleed		TIA			
Crohn's Disease		Irritable Bowel Syndrome		Carpal Tunnel Syndrome			
Cirrhosis		Gallstones		Dialysis			
Depression		Migraines		Coronary Artery Disease			
Peripheral Neuropathy		Seizure Disorder		Atrial Fibrillation			

Frequent Urinary Infections		Renal Failure		Fibromyalgia			

Past Surgical History:

Please check all that apply:

Tonsillectomy/Adenoidectomy		Carpal Tunnel Release		Other (Please Specify)	
Fundoplication		Vasectomy			
Cataract Surgery		Inguinal Herniorraphy			
Sinus Drainage		Ventral Herniorraphy			
Thyroidectomy		TURP			
Cervical Disk Fusion		Hemorrhoidectomy			
CABG		Meniscus Repair			
Coronary Artery Stenting		Varicose Vein Stripping			
Pacemaker insertion		Rotator Cuff repair			
Aneurysmectomy		Knee replacement			
Exploratory Laparoscopy		Hip replacement			
Appendectomy		Knee Arthroscopy			
Cholecystectomy		Skin cancer removal			
Splenectomy		Hysterectomy			
Partial Gastrectomy		Breast Surgery			
Femoro-popliteal Bypass Graft					

Family History:

Has any blood relative ever experienced any of the following conditions? Please describe:

Cancer:_____

Blood Disorder:_____

Patient Name:_____DOB:_____

Immediate family **********	Age of Onset	Recent Medical Conditions/ Diseases (i.e. Cancer, Diabetes, Heart attack etc.)	Deceased	Age at Death	Cause of death
Mother					
Father					
Brother/Sister					
Brother/Sister					
Brother/Sister					
Brother/Sister					

Current Health Screenings:

Health Screening	Most recent date performed
Colonoscopy	
Mammogram	
Stress Test	
Pap Smear	
Flu Vaccine	
Pneumonia Vaccine	
Other (Please Specify)	

Patient Signature:_____Date:_____

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PATIENT CONFIDENTIALITY RELEASE FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

Due to patient confidentiality issues, it is necessary that we have your permission to disclose your health information regarding your medical visits plus any additional information pertaining to your healthcare.

Please list below any family members and /or friends you authorize us to discuss your medical care with:

1. NAME: _____ PHONE: _____

   RELATIONSHIP: _____

2. NAME: _____ PHONE: _____

   RELATIONSHIP: _____

3. NAME: _____ PHONE: _____

   RELATIONSHIP: _____

PATIENT SIGNATURE: _____ DATE: _____

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Non-Covered Services
Patient Responsibility

Dear Patient:

We are asking you to sign this Non-Covered services form because there is a possibility that your insurance company may not cover some labs and outside testing services. Every contract is different. If your insurance does not cover one of these labs/services that your physician orders, you will receive a bill from that lab or outside testing service.

Date _____ Signature _____

Date of Birth _____

513 Brookwood Blvd Suite 275 • Birmingham, AL 35209 • Office: (205) 502-4700 • Fax: (877) 353- 3589

Serving patients in Birmingham, Fultondale, Gadsden and Sylacauga
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