PENNSYLVANIA CANCER SPECIALISTS
Research Institute

New Patient Information

Full Name: _____ Maiden Name: _____

DOB: _____ Soc. Security #:_____ Gender (*circle*): Male/Female

Address: _____

City: _____ State: _____ Zip: _____

Home PH: _____ Work PH: _____ Cell PH: _____

Email: _____ Access to our Patient Portal? Yes/No

Ethnicity (*circle*): Hispanic or Non-Hispanic Race: _____ Primary Language: _____

Marital Status (*circle*): Single Married Partner Divorced Separated Widowed

Employment (*circle*): Employed or Retired Employer: _____

Preferred Pharmacy Name: _____ Location: _____

Primary Care Physician: _____

Referring Physician: _____

Additional Provider(s): _____

The providers listed will receive communications from our office

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Do you have a Living Will? (*circle)*	Yes	No	Unknown
Durable Power of Attorney? (*circle)*	Yes	No	Unknown
Do Not Resuscitate Order? (*circle)*	Yes	No	Unknown

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL HEALTH INFORMATION

This authorization gives Satish A. Shah, M.D., PLLC permission to use and/or disclose health information about you. I authorize the release of health information as indicated above to the following representatives/family:

_____	_____	_____
Name (***Primary Contact)***	Relationship	Phone Number
_____	_____	_____
Name (***Primary Contact)***	Relationship	Phone Number
_____	_____	_____
Name (***Primary Contact)***	Relationship	Phone Number

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Medical History

Do you have diabetes? Yes or No

Do you have High Blood Pressure? Yes or No

Have you had a heart attack? Yes or No

Do you drink alcohol? Yes or No

Have you had exposure to any of the following? Chemicals Asbestos Radiation

Do you smoke? Yes or No

If yes:

How many years? _____

How many packs per day? _____

Do you have any allergies? (*Medications, Food, Environmental)*

Please list any medical problems or surgeries:

Please list current medications: (*prescriptions and over the counter)*

Use the back of this form if necessary and/or provide list to Front Desk to scan in

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Please describe your hospitalization history below:

Date: _____ Hospital: _____ Reason: _____

Date: _____ Hospital: _____ Reason: _____

Date: _____ Hospital: _____ Reason: _____

Female Patients

Gynecologic (*Please circle)* Abnormal Vaginal Bleeding Breast Biopsies Breast Lumps

Age At: 1st Period: _____ Menopause: _____ 1st Pregnancy: _____

Date of Last: PAP _____ Mammogram: _____ Bone Density: _____

Number of Pregnancies: _____ Number of Live Births: ____ Ever use Birth Control: _____

Have you ever used hormone replacement therapy: (*circle)* Yes No

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Family History:

Please indicate the number of siblings and children. Please list their medical, cancer, or blood problems if applicable. Do not list names of family members!

Father: _____ Mother: _____

Grandfather (*Paternal)*: _____ Grandfather (*Maternal)*: _____

Grandmother (*Paternal)*: _____ Grandmother (*Maternal)*: _____

Brother(s): _____ Sister(s): _____

Son(s): _____ Daughter(s): _____

Review of Symptoms: *(**Please circle** any of the following you may have experienced)*

Neurologic:	Headache	Eye Problems	Weakness	TIA
Head/Neck:	Sore Throat	Sinusitis	Thyroid Problems	
Respiratory:	Shortness of Breath	Cough	Coughing up Blood or Phlegm	
	Spit Blood	Asthma	Wheezing	
Cardiovascular:	Chest Pain	Angina	Heart Problems	Heart Attack
Gastrointestinal:	Indigestion	Heartburn	Constipation	Diarrhea
	Nausea	Difficulty Swallowing		
	Vomiting	Change in bowel habits		
Genitourinary:	Frequent Urination	Burning	Blood in Urine	Change in Stream
Endocrine:	Excessive Hunger	Excessive Thirst		
Constitutional:	Fever	Weight Loss	Feeling Cold	Hot Flashes
	Night Sweats			
Musculoskeletal:	Back Pain	Joint Pain	Joint Stiffness	Fractures
	Body/Muscle Aches	Bone Pain	Arthritis	
Psychological:	Depression	Anxiety	Bipolar Disorder	Sleep Problems
	Insomnia			

Do you have pain? Where? _____ Start Date: _____ Rate: _____
(0-10 with Ten being Severe)

What is the reason for your visit today? _____

Additional notes to discuss with the physician:

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Please read this entire document before signing

My signature authorizes the disclosure of all protected information for the purpose of review and evaluation in regards to my treatment with Satish A. Shah, M.D., PLLC I expressly request that the designated record custodian of all covered entities under HIPAA identified on this form full and complete protected medical information including as specified in the following: medical records, meaning every page in my record including but not limited to office notes, face sheets, history & physical, consultation notes, social worker records, discharge summaries, request for and reports of consultations, documents, correspondence, test results, billing records statements, pharmacy/prescription records, disability forms, questionnaires/histories, correspondence, photographs, videotapes, telephone message, and records received by other medical providers.

My signature or my appointed representative's signature certifies that I understand I have the right to revoke this authorization--in writing--at any time.

My signature or my appointed representative's signature certifies that I understand the information released in response to this authorization may be re-disclosed to other parties and that my insurance information is correct to the full extent of my knowledge.

My signature or my appointed representative's signature certifies Satish A. Shah, M.D., PLLC. to apply to my insurance for benefits on my behalf for covered services. I authorize the release to my insurers of medical and other coverage information necessary to process my claims. I request that my insurers pay directly to Satish A. Shah, M.D., PLLC any benefits to which I may be entitled for their services.

My signature or my appointed representative's signature certifies **I understand that I am responsible for all charges whether or not paid by insurance; this includes Co-Payments, deductibles, Co-Insurance (if applicable), charges not covered by insurance, etc. *NOTE: if my insurance fails to pay for my services with Satish A. Shah M.D., PLLC I understand that I may be billed and expected to pay for services rendered.***

My signature or my appointed representative's signature certifies my consent to the use and disclosure of my health information for treatment, payment, and health care operations purposes as mandated under HIPAA and described as above.

_____ _____

Print Patient or Personal Representative Name | Patient's Date of Birth

_____ _____

Sign Patient or Personal Representative Name | Date

This Authorization shall expire 12 months from the date executed

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Late Arrival Policy

Gettysburg and Hanover Cancer Center strive to provide thorough and timely care to each of our patients. In order to achieve this, we must remain on scheduled time with each patient visit. In the event a patient is running behind to a scheduled visit we request you contact our office staff prior to ensure the appointment is able to be kept. Any patient who arrives 10 minutes or longer after scheduled visit time will be asked to reschedule unless the provider can accommodate.

Cancellation Policy

Gettysburg and Hanover Cancer Center strive to provide thorough and timely care to each of our patients. In order to achieve this, we must understand the value in each appointment time we offer to our patients. In the event one is unable to keep a scheduled appointment we ask you to notify our staff within 24 hours so we can provide that empty appointment slot to another patient in need. In the event a cancellation is made within 23 hours of scheduled appointment time the patient will be charged a $20.00 cancellation fee.

No Show Policy

Gettysburg and Hanover Cancer Center strive to provide thorough and timely care to each of our patients. In order to achieve this, we must understand the value in each appointment slot we offer to our patients. In the event one is unable to keep a scheduled appointment we ask you to notify our staff within 24 hours so we can provide that empty appointment slot to another patient in need. In the event a patient no-show any visit without contacting our office a $35.00 no-show fee will be charged. If a patient no-shows three times they will be dismissed as a patient of Gettysburg and Hanover Cancer Center

_____ _____

Print Patient or Personal Representative Name | Patient's Date of Birth

_____ _____

Sign Patient or Personal Representative Name | Date

This Authorization shall expire 12 months from the date executed.

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PATIENT HEALTH QUESTIONNAIRE-PHQ-9

TO BE COMPLETED BY PATIENT. IF PATIENT'S REPRESENTATIVE IS COMPLETING FORM MAKE SURE THE PATIENT IS ANSWERING EACH QUESTION

Name: _____ DOB: _____ Date: _____

Please check if you have a history of: *1. Depression* ☐ *2. Bipolar Disorder* ☐
(If you have checked a box above – please do not proceed with questions below)

OVER THE LAST **2 WEEKS**, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

Please circle your choice:

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	0	1	2	3
Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that others could have noticed, or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself	0	1	2	3
If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	Not difficult	Somewhat difficult	Very difficult	Extremely difficult

TOTAL: _____