Cancer Care Center

Navneet Sharda, M.D.

PATIENT HISTORY SHEET

Name:______________________________ D.O.B:__________________

Diagnosis/Complaint:______________________________

Health History: (Please check any condition that you have or have had in the past)

- ☐ Cancer:______________________________
- ☐ Bowel/ Stomach:______________________________
- ☐ Pelvis/ Bladder:______________________________
- ☐ Bones/Muscles:______________________________
- ☐ Lungs/Breathing:______________________________
- ☐ Blood Disorders (Anemia, Diabetes, HIV, AIDS, Hepatitis, Thyroid, ect.)______________________________
- ☐ Heart/ Circulatory:______________________________
- ☐ Vision:______________________________
- ☐ Neurological:______________________________
- ☐ Other:______________________________

Note: If you have been under a doctor's care for any of the above condition, please list the doctor's Name and location:______________________________

Current Medications:______________________________

____

Allergies: (Medication, food, dust pollen ect.) ______________________________

Surgeries: (Please list year, hospital, location)

Appendectomy__________________ Bladder:__________________

Breast:__________________ Gallbladder:__________________

D&C:__________________ Eye:__________________

Hysterectomy:__________________ Hernia:__________________

Prostatectomy:__________________ Thyroid:__________________

Other:______________________________

Initials:__________

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PATIENT HISTORY SHEET
Continued

Social History:

Marital Status: _____Single ______Married ________ Widowed

How long have you lived in Nevada? ______________________________

In which state (country) were you born? ______________________________

What is/ was your occupation? ______________________________

Have you ever smoked or chewed tobacco? __________ For how long? ______________ When did quit?__________

Do you drink alcoholic beverages?____________ How often?__________________ How much?__________

Have you ever received Hormone Therapy or Chemotherapy? Yes_______ N0______

Medical Oncologist: Name______________________________ Address______________________________

Medication:______________________________Date Received: ______________________

Medication:______________________________Date Received:______________________

Have you ever re received Radiation Therapy: YES_______ NO_________

Radiation Oncologist's: Name_____________________ Address ______________________________

What area received radiation therapy?______________________________

Female:

Are you now, or is there a possibility that you might be pregnant? Yes_______ No________ **Initials:** _________Date:__________

Number of pregnancies:____________Deliveries:_____________________ Did you Brest Feed?__________

Have you ever taken Hormones? (Estrogens, Birth Control Pills, Androgens, ect.) Yes______________ No__________

If yes, for how long?______________________________

Do you still have menstrual periods? Yes_________ No____________ Date of last period ______________________

Family History:

Father: Age__________ If deceased, cause of death:______________________________

Mother: Age__________ If deceased, cause death:______________________________

Please list, by age, brother/ sisters

Name:____________________ Age:__________ If deceased, cause of death:______________________

Name:____________________ Age:__________ If deceased, cause of death:______________________

Name:____________________ Age:__________ If deceased, cause of death:______________________

Please list, by age, children:

Name:____________________ Age:__________ If deceased, cause of death:______________________

Name:____________________ Age:__________ If deceased, cause of death:______________________

Name:____________________ Age:__________ If deceased, cause of death:______________________

Note: Is there any history of cancer or blood diseases in any other family member such as: Grandparents, Uncles, Aunts, cousins, ect.?

If yes, please describe:______________________________

______________________________ ______________________

Patient signature **Date**

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Patient Registration

Last Name________________________ First Name________________ M.I.________

Address____

City____________________ State________________ Zip ______________

Phone No.______________ Cell Phone No.__________ Email______________

Date of Birth:____/____/______ Sex: M F Marital status: Single Married Widowed Separated

Social Security Number:______________________________________

Name of Employer:_________________________ Employer Phone:__________

Employer Address:____

Referred By:____

SPOUSE(Or parent, if a minor)

Name:____

Address______________________________ Phone No.:______________

Relationship____________________ Date of Birth:_________________

Social Security No.:____________________ Employer:______________

NEAREST RELATIVE **NOT** LIVING WITH YOU(for emergency contact)

Name:__________________________________ Phone No.____________

Address:________________________________ Cell No.:____________

Relationship:____

HEALTH INSURANCE INFORMATION

Primary____________________ Secondary ____________________

Policy No.__________________ Policy No.____________________

Group No.__________________ Group No.____________________

Insured Name________________ Insured Name ________________

Insured SS#_________________ Insured Name ________________

Date of Birth ______________ Date of Birth_________________

______________________________ ______________________________

Patient's signature **Date**

Cancer Care Center

Patient Authorization

Information Release:

I authorize medical information about me to be released to the Social Security Administration and Health Care Financing administration or its intermediaries, insurance carrics, or the billing agent for Cancer Care Center. Medical information released will be for the sole purpose of filing your insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original signature and request payment of insurance benefits to the party who accepts assignment.

Patient Signature:______________________________ **Date:**______________________

(If patient is unable to sign, may be signed by someone who is authorized by the patient to sign for him/her)

Authorized signature:______________________________ **Date:**______________________

Assignment and Release:

I herby authorize my insurance benefits, including Medicate gap fillers, to be paid directly to the physician. I herby agre to be financially responsible for all fees regardless of insurance coverage. I also authorize the physician to release any information required. In the event of collection proceeding due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to Cancer Care Center.

______________________________ ______________________

Patient Signature **Date**

(If patient is unable to sign, may be signed by someone who is authorized by the patient to sign for him/her)

______________________________ ______________________

Authorized signature **Date**

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Acknowledgement of Privacy Practices

I herby acknowledge that if I wish to request a copy of the Notice of Privacy Practices, I may do so at anytime with the Front Desk of Cancer Care Center.

Signature ______________________ **Date** ______________

Print Name ______________________ **Date** ______________

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Cancer Care Center

Imaging Services Notice

This Notice is being provided to you in compliance with the Patient Protection and Affordable sign into law March 23, 2010 ("PPAC Act).

As a patient of Cancer Care Center, Dr. Sharda, your physician, has ordered computed tomography (CT) as part of the diagnosis and treatment process.

Cancer Care Center provides this service in-house as a convenience for our patients. We are required by the PPAC Act to inform you that you may obtain such services from a person or entity other than Cancer Care Center.

We are also required by the PPAC Act to provide you with a list of suppliers who furnish such services in the area. Accordingly, please find a listed below the names of the suppliers (that we are aware of) who furnish such services in the counties where we provide care.

* West Valley Imaging* Desert Radiology* Red Rock Radiology* Sonoran Medical Imaging* Nevada Imaging Centers
* Diagnostic Imaging of southern Nevada* Steinberg Diagnostic Imaging

Please let us know if you have any questions.

______________________________ ______________

Patient Signature **Date**

INFORMED CONSENT FOR C.T. SCAN

The physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CAT scan to be the best diagnostic test for you after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

______________________________ Date ______________

Patient Signature

______________________________ Date ______________

Witness Signature

Cancer Care Center

Authorization For Release of Medical Records

I ____________________, Social Security number____-____-____,

date of birth____/____/____, herby authorize.

☐ Steinberg Diagnostic ☐ Desert Radiologists ☐ Nevada Imaging center
☐ Red Rock Radiology ☐ Diagnostic Imaging ☐ LMC ☐ Quest Diagnostics
☐ Hospital____________________
☐ DR.__________ ☐ DR.__________ ☐ DR.__________
☐ Other____________________ ☐ Other__________

To release any and all medical records, this shall include the following, to Sun Medical Group:

☐ Pathology Reports ☐ Radiology reports ☐ Consultations
☐ Labs ☐ Other____________________

____

____________________ **Patient Signature**

__________ **Date**

Fax To: Cancer Care Center
3509 E. Harmon
Las Vegas, NV 89121
(702) 547-2273
(702) 547-6818 **FAX**

Cancer Care Center

LIST OF PATIENT RIGHTS

This notification of patient rights is provided to you to comply with state and federal regulations. We respect your rights as a patient.

Patient Rights

You have the right to:

1. Considerate respectful and responsive care. The right to medical treatment regardless of age, sex, race, religion, disability or national origin.
2. Be treated in a dignified and respectful manner that supports your dignity.
3. Receive information from your physician about your illness, course of treatment and prospects for recovery in terms that can be understood.
4. Receive information about any proposed treatment or procedure as needed in order to give informed consent or to refuse this course of treatment.
5. Actively participate in decisions regarding your medical care to the extent permitted by law; this includes the right to refuse treatment.
6. Full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
7. To be advised as to the reason for the presence of any individual during medical evaluation.
8. To be free from neglect; exploitation; and verbal, mental, physical and sexual abuse.
9. To have complaints reviewed by the organization.
10. Confidential treatment of all communications and records pertaining to your care in the Cancer Care Center/Sun Medical Group. Written permission shall be obtained before your medical records can be made available to anyone not directly concerned with your care.
11. Reasonable responses to any rational requests you may make for service.
12. Receive an explanation of your bill regardless of source of payment.
13. To access, request amendment to, and obtain information on disclosures of his or her health information, in a accordance to the law.
14. Have all patients rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

______________________________ Signature

_______________ Date