PennState Health Medical Group

ANDREWS PATEL HEMATOLOGY/ONCOLOGY

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OFFICE LOCATIONS
3912 Trindle Road
Camp Hill, PA 17011
P: 717-761-8740
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Practice Site Manager - Camp Hill

4518 Union Deposit Road
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Oncology, Penn State Health
Community Medical Group

Hours of Operation
8am-5pm Monday-Thursday
8am-4:30pm Friday
24/7 Hospital & On-Call
www.andrewspatel.com

Dear _____,

Thank you for choosing **Penn State Health Medical Group Andrews Patel Hematology/Oncology**.

Your new patient appointment with _____ is on _____ at _____.

Your initial visit to our office may take 1 ½ - 2 hours

We would like to take this opportunity to welcome you to **Penn State Health Medical Group Andrews Patel Hematology/Oncology**. Our physicians and staff are dedicated to offering the highest quality patient care in a gentle, efficient and pleasant manner.

Office Hours:	Monday through Friday 8:00am to 5:00pm
Office Location:	3912 Trindle Road, Camp Hill, PA 17011
Office Entrance:	Entrance and parking are located at the back of the building.

This packet includes:

- New Patient Registration Form
- New Patient Self-Assessment Questionnaire
- See Your Chart letter
- Pain management agreement
- Financial Policy
- Patient Bill of Rights

Please complete and return the New Patient Registration form and the Self-Assessment Questionnaire prior to your appointment. Please mail these items back to us in the enclosed self-addressed stamped envelope.

For your First Visit, please bring:

- Driver's License
- ALL insurance and prescription cards

We are looking forward to meeting you and building a relationship that will ensure that you receive the highest quality of care and service. Because we treat a variety of diseases and patients who are more susceptible to infections, we ask that infants, children under age 12, visitors with cold or flu symptoms, and animals other than certified service animals refrain from visiting our office.

Sincerely,

Terri-Lee Christiana
Practice Site Manager – Camp Hill Office

PennState Health Medical Group

ANDREWS PATEL HEMATOLOGY/ONCOLOGY

New Patient Registration Form

(Please Print) Appointment Date:_____

PATIENT INFORMATION			
Dr. __ Mr. __ Mrs. __ Ms. __	First Name:	Middle:	Last:
Address:		Zip:	City & State:
Please indicate which number is primary by checking box: ☐ Home: ( ) ☐ Cell: ( ) ☐ Work: ( )		Social Security Number: DOB:	
Email Address:			Sex: ☐ Male ☐ Female

Marital Status:	Race:		Preferred Language:	Ethnicity:
☐ D	☐ American Indian	☐ White	☐ English	☐ Latino
☐ M	☐ Asian	☐ Other	☐ Spanish	
☐ S	☐ African American		☐ Other	☐ Non Latino
☐ W	☐ Pacific Islander		☐ Sign	

Spouse Name:	Spouse DOB and SS# (if insurance policy holder):
Are you a veteran: ☐ Yes ☐ No	Do you have any children?: ☐ Yes ☐ No # of sons: _____ # of daughters: _____
Referring Doctor:	Family Doctor:
Preferred Pharmacy:	Pharmacy Phone #:

HIPAA (include names of ALL persons we can release information to)			
Name	Relationship	Phone	Special Disclosures **
			Yes: ☐ No: ☐
			Yes: ☐ No: ☐
			Yes: ☐ No: ☐

** special disclosures include genetic testing, psychiatric, and drug and alcohol related information

Patient Name: _____

ID #: _____

FAMILY HISTORY

Family History of Cancer: *Have any of your blood relatives ever had cancer? Please include as much information about the cancer as you know.*

Relative	Type of Cancer	Age at Diagnosis	Current Age	Age at Death	Recurrence of cancer? Second Cancer diagnosis? Genetic Testing?
You					
Mother					
Mother's Mother					
Mother's Father					
Father					
Father's Mother					
Father's Father					
Brother or Sister					
Brother or Sister					
Brother or Sister					
Child ☐Male ☐Female					
Child ☐Male ☐Female					
Other Blood Relative:					
Other Blood Relative:					

Other Family Medical Conditions: *Please list any family members who have had the following medical problems.*

Condition	Relative
Diabetes	
High Blood Pressure	
Heart Disease	
Stroke	
Psychiatric Problems	
Substance Abuse	
Other	

Patient Name: _____

ID #: _____

Have you ever had a colonoscopy? ☐ Yes ☐ No When _____

Have you ever received a **blood transfusion**? ☐ Yes ☐ No When _____

Do you have a living will? ☐ Yes ☐ No

Do you have a durable power of attorney? ☐ Yes ☐ No

Do you have a DNR (Do Not Resuscitate)? ☐ Yes ☐ No

** If yes to any of the above, please provide a copy for your medical record.

OTHER MEDICAL PROBLEMS - not described above

_____

_____

_____

_____

o

SHOTS

When was your last Tetanus shot? Year_____ ☐ Never ☐ I don't know

When was your last Pneumonia shot? Year_____ ☐ Never ☐ I don't know

When was your last Flu shot? Year_____ ☐ Never ☐ I don't know

FOR WOMEN ONLY

Have you ever been **pregnant**? ☐ Yes ☐ No

How many times? _____

How many children have you given birth to? _____

Have you had a **PAP smear**? ☐ Yes ☐ No

Date of last one _____

Have you ever had a **PAP smear that was not normal**? ☐ Yes ☐ No

Have you had a **mammogram** (breast x-ray)? ☐ Yes ☐ No

Date of last one _____

SOCIAL HISTORY

Current Occupation/Employer:_____ Type of work: _____

Have you been exposed to any chemicals (toxic fumes, asbestos, etc?) ☐ Yes ☐ No

Have you ever smoked cigarettes, cigars, used snuff, or chewed tobbacco?

☐ Yes (If yes, complete the following) ☐ No

a. When did you start?_____

b. What type? _____

c. How much per week? _____

d. Have you quit? ☐ Yes ☐ No When? _____

e. Do you want to quit? ☐ Yes ☐ No ☐ Already Quit

Do you drink alcohol?

☐ Yes (If yes, complete the following) ☐ No

a. _____ beer per: ☐ day ☐ week ☐ month

b. _____ glasses of wine per: ☐ day ☐ week ☐ month

c. _____ mixed drinks per: ☐ day ☐ week ☐ month

d. Any prior or current history of alcohol abuse? ☐ Yes ☐ No

Do you use recreational drugs?

☐ Yes (If yes, complete the following) ☐ No

a. When did you start?_____

b. What type? _____

c. How much per week? _____

d. Have you quit? ☐ Yes ☐ No When? _____

e. Do you want to quit? ☐ Yes ☐ No ☐ Already Quit

Patient Name: _____

ID #: _____

MEDICATIONS - Please list all medications, including prescription, over the counter, vitamins, supplements, and herbs.		
Name	Dose	# times per day
Example: Aspirin	Example: 325 mg	Example: once daily

SURGERIES - Please list all surgeries and dates below.

_____

_____

_____

_____

ALLERGIES - Please list all drugs, food and environmental allergies, including latex powders, etc. that you have an allergy to.

Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	
Name		Reaction	

PRIVACY NOTICE

Upon arrival at the office on the day of your first appointment, you will be asked to sign off on the Penn State Health Medical Group Notice of Privacy Practices. This document is posted at the front desk in each office for you to view. You may request a complete copy for your reference.

Patient Name: _____

Date: _____

New Patient Self-Assessment Questionnaire

Fatigue/Weakness

- ☐ Mild
- ☐ Moderate
- ☐ Disabling

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Hot flashes

Pain

Level (0 no pain - 10 worst pain) _____

Location _____

Description:

- ☐ Dull
- ☐ Throbbing
- ☐ Steady
- ☐ Sharp
- ☐ Chronic/persistent
- ☐ Between doses of pain medication

- ☐ **Mouth Sores**
- ☐ **Swelling?**

where? _____

- ☐ **Shortness of breath when resting?**
  - ☐ New ☐ Same ☐ Worse
- ☐ **Shortness of breath with activity?**
  - ☐ New ☐ Same ☐ Worse

Please explain: _____

- ☐ **Loss of appetite**

Nausea

- ☐ With loss of appetite, but still eating usual amounts
- ☐ With decreased food and/or liquid intake
- ☐ With vomiting

How much? _____

- ☐ **Difficulty swallowing**
- ☐ **Heartburn**

Constipation

- ☐ Occasional use of change in diet/stool softeners/laxative
- ☐ Persistent with regular use of laxatives or enemas
- ☐ Worse than above

Diarrhea

- ☐ 4 more than my normal per day
- ☐ 4-6 more than my normal per day
- ☐ 7 more than my normal per day

Rash

Where? _____

Numbness or Tingling

Where? _____

☐ New ☐ Same ☐ Worse

Do you have the following documents? If yes, please provide copies to our office so that we can follow your wishes. Thank you.

	Yes	No
☐ **Living Will**	☐	☐
☐ **Durable Power of Attorney**	☐	☐
☐ **Do Not Resucitate (DNR)**	☐	☐

Check ONLY ONE BOX to describe your activity level:

- ☐ Active. No limitations.
- ☐ Able to complete light house or office work. Unable to complete strenuous activity. Up and about more than 50% of waking hours.
- ☐ Able to walk around home and able to bathe and dress self. Unable to carry out work activities beyond self care.
- ☐ Limited activity and self care. Spend most of the day in bed or chair.
- ☐ Unable to get out of bed. Unable to care for self.

Are there any other concerns or symptoms you'd like to discuss at your visit? Please list them here:

_____

_____

Patient Health Questionnaire (PHQ-9)

Complete the screening by answering the following questions

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than 1/2 of the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself -- or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people 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
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____+ _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

We understand some questions within this assessment may feel very personal and we respect your choice if you prefer not to complete all or part of the assessment. We feel the information will assist us in providing you with the best individualized care.

Thank you, The Physicians

** Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. More information about this and other screeners can be found at http://www.phqscreeners.com/ .*

SeeYourChart® Information

Dear Patient,

We are pleased to offer you access to our secure online patient portal - SeeYourChart®.

Using SeeYourChart® will allow you to access your medical record from any computer or tablet device with an Internet connection. You (or those people you authorize), can view, print, or save a copy of your clinical information such as laboratory reports, diagnostic test results, clinical summary documents, upcoming appointments, and even patient education resources!

We remain committed to providing you with the most compassionate care possible, as such there may be times when certain test results will only be disclosed during a direct discussion with your physician such that all your questions can be answered fully.

Ready to participate?

Please be prepared to provide the receptionist with a valid email address upon your first check-in. You will then receive an email providing you with the steps to enroll in SeeYourChart®. If you do not have an email address, our staff can assist you in setting up a user name and password.

You will then have access to your patient portal anytime day or night via our website:

www.andrewspatel.com

SeeYourChart® is just one way we are here for you, fully committed to providing excellent care. For a demonstration of how SeeYourChart® works, please visit our website www.andrewspatel.com and click on the patient portal button on the lower left corner of the home screen.

Sincerely,

The Physicians

(Dr. Peroutka, Dr. Gareis, Dr. Simmonds, Dr. Surapaneni, Dr. Shipley, Dr. Shah, Dr. Liu, Dr. Rao, Dr. Cheng, and Dr. Ravella)

Penn State Health Medical Group
Andrews Patel Hematology/Oncology
Pain Management Agreement

Introduction

Our philosophy is pain reduction and pain management. For certain individuals, controlled substances can help control pain and return them to more functional living. Controlled substance use is under the control of several regulatory agencies. Physicians need to strictly abide by the local, state, and federal regulations when prescribing controlled substances. Thus, our physicians have developed the following standards of conduct for our patients.

Patient Obligations – Standards of Conduct

- I will communicate fully with my doctor about my pain and response to treatment.
- I will not use any illegal controlled substances, including marijuana, cocaine etc.
- I will not share, sell, or trade my medications with anyone.
- I will safeguard my pain medicine from loss or theft. **I understand that lost or stolen medications will not be replaced until time for the next fill.**
- I will not attempt to obtain controlled medications from any other doctor or pharmacy that are being prescribed by Andrews and Patel Associates, P.C.
- **I understand that refills of my pain medicine will be made only during regular office hours.**
- I understand that it may take 3-5 business days for refill of medications and I will call in advance for refills to allow for this.
- I agree to submit to a blood or urine test if requested by my doctor to determine compliance with my pain control medicine.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time (in other words – a request for a refill too soon may not be granted).
- I will bring all unused pain medicine to every office visit if requested by my physician.

Summary

Long term pain management depends on adherence to the above principles and maintenance of an effective doctor-patient relationship. I understand that:

- cessation of pain management therapy will be at the discretion of the physician
- this agreement may be shared with other health care providers
- if I break this agreement, my doctor may stop prescribing pain medications

During your first office visit, you will be asked to electronically sign our Pain Management Agreement acknowledging that you have read it. A copy is available for review at the front desk as well.