Patient Information/ Insurance Information

Dallas Ft. Worth Sarcoma Group, PA

Today's Date: __________________ Appointment With: Dr. Maale or Dr. Casas

Patient Information

Who Referred You? ____

Last Name First Name Middle (Maiden) Nickname

Street Address Suite/Apt. No. City State Zip

Home Phone Cell Phone E-Mail Address

Employer Name Address Phone Number Position Spouse/Guardian

Medication Allergies Emergency: Contact Name Phone No. Relationship

Insurance Information

Insured's Last Name First Name Middle Date of Birth

Primary Insurance Carrier Policy No. Group No. Date of Birth

Secondary Insurance Carrier Policy No. Group No. Date of Birth

Please Present Card(s) to Front Desk Receptionist with a Picture ID to copy for your records.

DFWSG, PA filing of claims is a courtesy we provide to you for your convenience. Your contract is between you and your Health Insurance Carrier. The insured is ultimately responsible for all services rendered. ***You are responsible to provide current and accurate insurance information. You are responsible for all copays, deductibles, non-covered services, untimely payments or balances denied due to your failure to provide DFWSG with current, complete and accurate information.***

We do not file secondary claims. Please make sure you have arranged with your Primary Carrier to electronically "cross-over" your claim automatically to your Secondary Coverage. Our Billing Dept. will gladly assist you with any questions regarding Secondary Claims.

I consent to services recommended by DFWSG,PA including diagnostic procedures, examinations and treatment that the physician designates and considers to be necessary for the treatment of my conditions.

I certify that I have read all of the above information. I have provided DFWSG with current, accurate information.

Signature Date Print Name

Updated: 10/01/2010

The following information is very important to your health. Please take the time to fully and accurately fill out this this form.

Patient Name: ____________________________ Date: ________________

History of present illness: do you have a mass(lump)_________or lesion______or pain_____
Location on your body_________________________________ ____Left _____Right
When was your first symptom or signs of problem? _______________How long have you had this?________
Severity of pain, please rate on a scale of 1 to 10 (10 being the most painful)___________
Is the pain: sharp or dull, aching or stabbing or throbbing constant or happens sometimes
What activities cause the pain?____
Have you fallen in the past year? Yes NO how many times?______________
Past Medical History
Childhood diseases:___________________________________Last Tetanus
Vaccine:_______________________Major
Illnesses:____
Have you ever had general anesthesia? YES NO Have any problems with anesthesia? YES NO
Describe____

Surgeries	Dates	Complications

General: Weight_______ Height__________ Age____
If female list date of last Pap________mammogram_________

Social History: What do you do for employment?_________________homemaker______student____

Smoker: Yes No Previous smoker: Yes No How many packs?_______years?______Year quit?______

The US Surgeon General has said, "Smoking cessation [stopping smoking] represents the single most important step that smokers can take to enhance the length and quality of their lives."

Do you consume alcohol: Yes No How often:____ daily ______weekly _______monthly
Do you wear your seat belt? always sometimes never

Exercise: Daily Weekly Monthly Rarely Never What type of exercise?
____
Are you on a special diet? YES NO Describe_________________________________
History of substance abuse? YES NO What?_________________________________
Do you live alone? YES NO
When was the last you saw a dentist?____

Allergies to medications:____

Family History. Do any of the following family members have heart, kidney, respiratory problems or cancer?

Member	Alive	Deceased	Age	Health status or cause of death
Mother	A	D	_____	_________________________________
Father	A	D	_____	_________________________________
Brother	A	D	_____	_________________________________

Sister A D _____ ________________________________

List the doctors you have seen for this problem:____
Address:__________________________________ Phone and fax #:__________________________________
List your Primary Care Physician: _____________________________ Address:_________________________
Phone & fax #_______________________________________

Please mark x-rays and special radiographic scans, blood work, biopsies, medical records you have had for this problem and you have brought to your appointment for physicians review.
______MRI _______CT _______Bone Scan ______Plain X-Rays__________Blood work

_______Histology slides(previous biopsy)_______Past medical records

Patient Name:____ **Date**: _________________________

Review of Systems: **Please check any that apply to your current state of health.**

Constitutional: _____Weight loss _____weakness_____Fatigue _____Fever/Chills______None

Eyes: _____Vision changes _____Double vision____________None

Ear/Nose/Mouth/Throat: _____Nasal drainage_____Sneezing_____Hoarseness_____Hearing loss_____ Ear pain____Ringing of ears_____Nose bleeds_____None

Neck: _____Masses _______tenderness___________None

Respiratory: _____Cough _____Wheezing_____Shortness of breath_____Asthma_____None

Cardiovascular: _____Heart murmur_____Ankle swelling _____Nausea_____High blood pressure _____Chest pain_____None

Chest (breasts): ____mass _____nipple discharge_____tenderness_____history of breast cancer_____None

Gastrointestinal: _____Diarrhea_____Constipation_____Urinary pain_____Blood in urine ____Blood in stools_____Vomiting_____Heart burn_____None

Genitourinary: _____Genital discharge ____Urinary frequency_____None

Lymphatic(neck, axilla, groin, other):_____Lymph node changes_______Swelling_____None

Musculoskeletal: any pain in_____neck ___upper back____lower back____shoulder____arm____hip___thigh _____leg____foot____limp____mass_____loss of muscle strength_____None

Skin: _____Rash_____lesions_____ulcers_____open wound______drainage_____None

Neurologic: _____Seizure_____Stroke_____Paralysis_____Muscle weakness_____Unconsciousness ____Memory changes_____None

Psychiatric: _____Anxiety_____Suicidal thoughts_____Depression_____Sleep disturbance____Agitation_____None

If you have checked any of the above, please explain below:

____

____

____

____

____

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I attest that the above information is true and correct to the best of my knowledge.

Patient Signature:____

Who filled out this form if other than patient:____________________Relation:________________

MEDICATION FLOW SHEET

PATIENT NAME____

ALLERGIES____

PLEASE LIST **ALL** MEDICATIONS YOU ARE TAKING Pharmacy #___________________

Date	Medication	Dosage	Reason	Initial

Patient Name______________________________**Date**_________________________

Physical Exam: **Vital signs:** pulse________ resp________ temp_____

Appearance: well developed, well nourished, well groomed, obese, thin

Mood and Affect: alert, attentive **Orientation:** person, place & time

Gait: ataxia, limp, normal , N/A **Use of assistive device**: Yes No
type: wheelchair, walker, crutches, cane

Musculoskeletal Assessment:

Circle site of complaint: **LLE** **RLE** **LUE** **RUE** **Neck** **Spine/Pelvis**

Range of Motion full full full full full
full (crepitation)
Asymmetry no no no no no no

Masses	no	no	no	no	no	no
Effusion	no	no	no	no	no	no
Stability(Laxity)	no	no	no	no	no	no
Muscle atrophy	no	no	no	no	no	no
Deep Tendon Reflexes	+	knee	-	+	elbow	-
Lymph nodes	no	no	no	no	no	no
Skin(rash,lesion,ulcers)	no	no	no	no	no	no

Assessment by:__________________

REVIEWED BY:______________________,MD DATE:_________________