

**Ohio Cancer Specialists**  
1125 Aspira Court  
Mansfield, Ohio 44906  
**Patient Information Form**

**Patient Name** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Do you have Insurance? \_\_\_\_\_

Insurance Company Name and Address \_\_\_\_\_

Phone \_\_\_\_\_ Subscriber \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ Phone \_\_\_\_\_

Person financially responsible for this account \_\_\_\_\_

In case of emergency, please contact \_\_\_\_\_ Phone \_\_\_\_\_

Do you have a living will? \_\_\_\_\_ May we have a copy of your living will? \_\_\_\_\_

Please feel free to discuss any questions regarding advance directives with our physicians.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Primary Physician \_\_\_\_\_

Surgeon \_\_\_\_\_

# Ohio Cancer Specialists

## CONSENT TO RELEASE INFORMATION

I, \_\_\_\_\_ give the physicians and the office staff of Ohio Cancer Specialists, permission discuss my medical condition (please list family members and friends only, not other physicians), to the following:

_____	Relationship _____
Phone # _____	
_____	Relationship _____
Phone # _____	
_____	Relationship _____
Phone # _____	
_____	Relationship _____
Phone # _____	

Ohio Cancer Specialists MAY \_\_\_\_\_ MAY NOT \_\_\_\_\_ leave messages regarding appointments, test results, or other information on my answering machine. Ohio Cancer Specialists MAY \_\_\_\_\_ MAY NOT \_\_\_\_\_ leave messages regarding appointments, test results, or other information on the answering machines of any of the above-appointed people. We will leave NO information on any answering machine which does not identify the owner either by name or by the phone number called.

I understand that cellphones may or may not be safe as to privacy.

This is an indefinite consent form unless otherwise specified.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Review of Systems

Do you now or have you had any problems related to the following systems? **Circle Yes or No**

**Please explain any Yes answers in space provided.**

**Constitutional Symptoms**

Fever                            Y    N  
 Chills                            Y    N  
 Headache                        Y    N  
 Other \_\_\_\_\_

**Eyes**

Blurred vision                 Y    N  
 Double vision                 Y    N  
 Pain                                Y    N  
 Other \_\_\_\_\_

**Allergic/Immunologic**

Hay Fever                        Y    N  
 Drug allergies                 Y    N  
 Other \_\_\_\_\_

**Neurological**

Tremors                         Y    N  
 Dizzy spells                    Y    N  
 Numbness/tingling            Y    N  
 Other \_\_\_\_\_

**Endocrine**

Excessive thirst                Y    N  
 Too hot/cold                    Y    N  
 Tired/sluggish                 Y    N  
 Other \_\_\_\_\_

**Gastrointestinal**

Abdominal pain                Y    N  
 Nausea/vomiting               Y    N  
 Indigestion/heartburn        Y    N  
 Other \_\_\_\_\_

**Cardiovascular**

Chest pain                        Y    N  
 Varicose Veins                 Y    N  
 High blood pressure            Y    N  
 Other \_\_\_\_\_

**Integumentary**

Skin rash                        Y    N  
 Boils                             Y    N  
 Persistent itch                 Y    N  
 Other \_\_\_\_\_

**Musculoskeletal**

Joint pain                        Y    N  
 Neck pain                        Y    N  
 Back pain                        Y    N  
 Other \_\_\_\_\_

**Ear/Nose/Throat/Mouth**

Ear infection                    Y    N  
 Sore throat                      Y    N  
 Sinus problems                 Y    N  
 Other \_\_\_\_\_

**Genitourinary**

Urine retention                 Y    N  
 Painful urination               Y    N  
 Urinary frequency             Y    N  
 Other \_\_\_\_\_

**Respiratory**

Wheezing                        Y    N  
 Frequent cough                 Y    N  
 Shortness of breath            Y    N  
 Other \_\_\_\_\_

**Hematologic/Lymphatic**

Swollen glands                 Y    N  
 Blood clotting problem        Y    N  
 Other \_\_\_\_\_

**Psychologic**

Are you generally satisfied with your life?    Y    N  
 Do you feel severely depressed?                Y    N  
 Have you considered suicide?                    Y    N  
 Other \_\_\_\_\_

**Physician use only: (Comments/Notes)**

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Donald L. Dewald, M.D.  
Saurabh B. Das, M.D.

*Diplomates of American  
Board of Medical Oncology*

Shahzad Khan, M.D.

*Hematology/Oncology*

## FINANCIAL POLICY

It is the policy of Ohio Cancer Specialists to file an insurance claim for you if you provide complete and accurate information. For patients with no insurance or who choose to file their own claim, we ask that payment be made at the time services are rendered.

We will, on request, provide you with a complete list of our fees. We understand that treatment can be expensive, and will assist you with your insurance as much as possible. However, it is your ultimate responsibility for any charges incurred.

We ask that all co-pays are paid on the date of service. This is a part of your contract with your insurance company, and we are required to collect them.

If you have questions, please call our billing department at 419-756-0746.

I have read and understand the Financial Policy for Ohio Cancer Specialists.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_  
(Patient signature or state relationship if signing for patient)

Witness \_\_\_\_\_

Date \_\_\_\_\_