

**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? \_\_\_\_\_

Place of Employment \_\_\_\_\_

Work Phone \_\_\_\_\_ May we contact you at work? Y or N

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 \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Do you reside in a nursing home? \_\_\_\_\_ Y \_\_\_\_\_ N

# OHIO CANCER SPECIALISTS

## CONSENT TO RELEASE INFORMATION

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone# \_\_\_\_\_

May we leave a message on your answering machine regarding appointments, test results, or other information: Y or N

May we leave a message on your friends or relatives answering machine regarding appointments, test results, or other information:  
Y or N

We will leave NO information on any answering machine which does not identify the owner either by name or by the phone number called.

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

MAIN CAMPUS  
1125 Aspira Court • Mansfield, Ohio 44906  
419-756-2122 • fax 419-756-3550

SHELBY OFFICE  
31 East Main Street • Shelby, Ohio 44875  
419-342-2775 • fax 419-342-2237

WILLARD OFFICE  
1509 Corwell Avenue • Willard, Ohio 44890  
419-933-4424 • fax 419-964-0212

1.877.4.HOPE.RX  
www.ohcancer.com

# OHIO CANCER SPECIALISTS

- Chemotherapy
- Radiation Therapy
- PET/CT Scanner
- National Clinical Trials
- In-House Pharmacy
- Nationally Certified  
Chemotherapy Nurses
- Electronic Medical Records

*Hope • Compassion • Care*

*One Location • Comprehensive Cancer Therapy*

Donald L. Dewald, M.D.  
*Diplomate of American  
Board of Medical Oncology*

Saurabh B. Das, M.D.  
*Diplomate of American  
Board of Medical Oncology*

Shahzad M. Khan, M.D.  
*Diplomate of American  
Board of Medical Oncology and Hematology*

Munir Ahmad, M.D.  
*Diplomate of American  
Board of Radiology*

## 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.

While we will assist you in dealing with insurance companies, ultimately it is your responsibility for any charges incurred. Any insurance balance over 45 days will become your responsibility and will be due immediately. Any balance over 90 days will be considered delinquent.

If the entire patient balance cannot be paid when you come into the office, you will need to speak with a member of the billing department to determine if acceptable arrangements can be made.

We will, upon 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.

All co-pays are due on the date of the visit. It is your responsibility to check the terms of your policy to determine whether you will owe a co-pay for only office visits with the physician or nurse, or whether there is a co-pay on chemotherapy, radiation visits, radiology and lab. This will be outlined in your policy manual. If you would like to bring this manual to our office, a member of the billing staff will be glad to go over it with you.

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 of state relationship if signing for patient)

Witness \_\_\_\_\_

Date \_\_\_\_\_

**Acknowledgment of Receipt of Privacy Notice**

I, \_\_\_\_\_, have received the Notice of Privacy Practices from  
Ohio Cancer Specialists, Inc.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

In lieu of patient's signature, I \_\_\_\_\_, a staff member of Ohio  
Cancer Specialists, Inc., state that \_\_\_\_\_ has been given our current Notice of  
Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date