

PATIENT INFORMATION DATA
UNIVERSITY OF CHICAGO MEDICAL CENTER FOR HEMATOLOGY/ONCOLOGY
Phone :773-702-6149 - Fax:773-834-7072



PLEASE PRINT

Patient Name _____ Sex: M F
Address _____ Marital Status S M W D
City _____ State _____ Zip _____ SS# _____
Home Phone# _____ DOB _____
Work Phone# _____ Student Y N
Employer _____ Address _____
Is this a work related injury? Y N Is this a result of an auto accident? Y N

HEAD OF HOUSEHOLD

Name _____ Home Phone # _____
Address _____ Work Phone # _____
City _____ State _____ Zip _____
Employer _____ Address _____
Spouse _____ DOB _____

PRIMARY INSURANCE INFORMTION

Primary Insurance Company _____
Address _____ City _____ State _____ Zip _____
Plan ID# _____ Group# _____ SS# _____
Subscriber Name _____ Employer _____
Address _____ Home Phone # _____
City _____ State _____ Zip _____ Work Phone# _____
Subscriber's DOB _____ Relationship _____

SECONDARY INSURANCE INFORMATION

Primary Insurance Company _____
Address _____ City _____ State _____ Zip _____
Plan ID# _____ Group# _____ SS# _____
Subscriber Name _____ Employer _____
Address _____ Home Phone # _____
City _____ State _____ Zip _____ Work Phone _____
Subscriber's DOB _____ Relationship _____
Referred by: PPO/HMO Relative Friend Physician Newspaper Prologue Hospital Radio Other

IN CASE OF EMERGENCY:

Notify _____ Relationship _____ Phone # _____

AUTHORIZATION TO TREAT:

I hereby authorize insurance benefits to be paid directly to the aboce signed provider, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of patient or Legally Authorized Representative

Date

Patient Account#



Patient Name: _____ Date: _____
 Date of Birth: _____ SS#: _____
 Referring Physician: _____ Advance Directives: Y N
 Allergies: Y N Living Will: Y N

SURGICAL HISTORY

Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____
 Year _____ Surgery _____

MEDICAL HISTORY

Do you have a history of:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes:	_____	
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Location:	_____	
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Duration:	_____	
Heart Oproblems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	On a scale of 1 to 10 with 10 being the worst:	_____	
Arthritis/Gout	Yes <input type="checkbox"/>	No <input type="checkbox"/>	1 2 3 4 5 6 7 8 9 10	_____	
Convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Medications taken for pain:	_____	
Bleeding tendency	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	
Veneral Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	
Heredity Defects	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>		_____	



PATIENT SOCIAL HISTORY

Marital Status S M W S D

Use of Alcohol: Never Rarely Moderate Daily

Use of tobacco: Never Previously but quit _____ Years _____

currently smokes Packs per day _____ Years _____

Use of drugs: Never Type/Frequency: _____

Excessive exposure at home or work to:

Airborn particles Dust Fumes Solvents

Other: _____

MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

HOSPITALIZATIONS

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____



SYSTEM REVIEW

Please check **YES** or **NO** to the following

Constitutional Symptoms

- Recent weight change Yes No
- Fever Yes No
- Fatigue Yes No
- Headaches Yes No

Eyes

- Eye disease/injury Yes No
- Wear glasses/contacts Yes No
- Blurred or double vision Yes No
- Glaucoma Yes No

Ears/Nose/Mouth/Throat

- Earaches/drainage Yes No
- Chronic sinus problems Yes No
- Nose bleeds Yes No
- Mouth sores Yes No
- Bleeding gums Yes No
- Sore throat/voice change Yes No
- Swollen gland in neck Yes No

Cardiovascular

- Heart trouble Yes No
- Chest pain Yes No
- Palpitations Yes No
- Shortness of breath Yes No
- Swelling of feet & ankles Yes No
- Varicose veins Yes No

Respiratory

- Chronic or frequent coughs Yes No
- Spitting up blood Yes No
- Shortness of breath Yes No
- Asthma or wheezing Yes No

Gastrointestinal

- Loss of appetite Yes No
- Change in bowel movements Yes No
- Nausea or vomiting Yes No
- Frequent diarrhea Yes No
- painful bowel movements Yes No
- Constipation Yes No
- Blood in stool/bleeding Yes No
- Abdominal pain Yes No
- Heartburn Yes No
- Ulcers Yes No

Genitourinary

- Frequent urination Yes No
- Burning/painful urination Yes No
- Blood in urine Yes No
- Incontinence or dribbling Yes No
- Kidney stones Yes No
- Male-testicle pain Yes No

Females

Menstrual history:

Age of onset: _____
 Regular Irregular

Length of Cycle: _____

SYSTEM REVIEW (CONTINUED)

Genitourinary (Continued)

Number of pregnancies _____
 Number of Live births _____
 Number of miscarriages _____
 Last pap smear _____
 Last mammogram _____
 Menopause Yes No
 if yes, age of onset _____

Please check **YES** or **No** to the following:

Musculoskeletal

Joint pain Yes No
 Joint stiffness/swelling Yes No
 Muscle pain/cramps Yes No
 Back pain Yes No
 Cold extremities Yes No
 Difficulty in walking Yes No
 Bone fractures/injuries Yes No

Skin/Breast

Rash or itching Yes No
 Change in skin color Yes No
 Change in hair or nails Yes No
 Breast lump/pain/discharge Yes No

Neurological

Frequent or recurring heads Yes No
 Light headed or dizzy Yes No
 Convulsions/seizures Yes No
 Numbness or tingling Yes No

Neurological (continued)

Tremors Yes No
 Paralysis Yes No
 Stroke Yes No
 Head injury Yes No
 Yes No

Psychiatric

Memory loss/ confusion Yes No
 Nervousness Yes No
 Depression Yes No
 Insomnia Yes No
 Mental illness Yes No

Endocrine

Hormone problems Yes No
 Thyroid disease Yes No
 Excessive thirst Yes No
 Excessive urination Yes No
 Heat/cold intolerance Yes No

Hematological

Slow to heal after cuts Yes No
 Bleeding or bruising Yes No
 Anemia Yes No
 Phlebitis Yes No
 Past transfusions Yes No
 Enlarged glands Yes No

Allergic

History of skin reactions to: Yes No
 Penicillin or antiotics Yes No
 Moripine or Demoral Yes No
 Novacaine/anesthetics Yes No

Other Drugs: _____

Food allergies _____

Pt. Label Here



Coordination of Benefits Questionnaire

Please print using blue or black ink

Your insurance plan may contain a Coordination of Benefits (COB) provision. COB clarifies which plan is *primary* and *secondary* when two or more health insurance plans cover the patient. We need to learn about any health insurance coverages you may have.

Name of Primary Insurance Carrier:	
Policyholder Name:	
Policy/Member ID #:	
Group #:	

OTHER INSURANCE:

Is the patient covered by another medical or dental insurance policy or any other policy? *Please check one*

- No, I don't have any other insurance:**
If *No*, please sign, date and return this questionnaire.
- Yes, I have additional insurance: (Health or Dental - circle one)**
If *Yes*, please complete Section A below, then sign, date and return this questionnaire.

List dependent(s) on both policies	Relationship	Date of Birth	Sex	Effective Date
			M or F	
			M or F	
			M or F	

Section A: Secondary Insurance Policy Information

Type of Policy/Plan (circle one): Group Individual Medicare Medicare Supplemental Student

Name of Secondary Insurance Carrier:	
Policyholder Name:	
Policy/Member ID #:	
Group #:	
Policyholder's Date of Birth:	
Effective Date of Policy:	
Insurance Carrier Address:	
Insurance Carrier City, State, Zip:	
Insurance Carrier Phone Number:	

Is the policyholder:
Actively working? YES / NO Inactive or Retired? YES / NO (if yes-Retirement Date: ___/___/___)

If on COBRA, this began: ___/___/___

Employer Information	
Policyholder's Employer:	
Employer's Address:	
Employer's City, State and Zip:	
Employer's Phone Number:	

Signature of Policy Holder Required: _____ **Date:** ___/___/___

“COB” – Coordination of Benefits

You have been asked to fill out the “COB form” because you have a commercial insurance plan. Many insurance companies will delay payment on your claim until they clarify your coverage details. If you only have one insurance plan, completing and signing this form may help expedite payment on your claim; if you have two plans, this form will help avoid delays in payments and prevent payments in excess of 100% of charges.

COB was established as a method by which two or more carriers or plans could coordinate their respective benefits. In Illinois, the COB Regulation specifies how benefits are to be coordinated by insurance companies issuing group policies in the state.

Who Pays First? Who Pays Second?

The primary carrier is the plan that pays first, the secondary carrier pays second and on down the line. The COB Regulation provides guidelines for the general order by which the primary carrier and secondary carrier(s) are determined as follows:

Employee, Member or Subscriber

- The plan that covers you as an employee, member or subscriber is primary over the plan that covers you as a dependent.
- The plan that covers you as an active employee (not as a laid-off employee or retiree) is primary over the plan that covers you as a laid-off employee or retiree.
- If you are covered as an employee, member or subscriber under more than one plan, but are covered under state or federal continuation (COBRA) under one of the plans, then:
 - The plan covering you as an employee, member or subscriber is primary over the plan covering you under state or federal continuation (COBRA).
- If you are covered as an employee, member or subscriber under more than one plan, and none of the above rules apply, then:
 - The plan that has been in effect the longest is primary, back to your original effective date under your employer group, whether or not the insurance company has changed over the course of coverage.

Dependent Children of Parents Not Separated or Divorced

- Birthday Rule - The plan covering the parent whose birthday falls earlier in the year is the primary carrier.
- If both parents have the same birthday, the plan that has provided coverage longer is the primary carrier.

NOTE: Birthday refers only to the month and day in a calendar year, not the year in which the person was born.

Dependent Children of Separated or Divorced Parents

If your child is covered by more than one group plan and you are separated or divorced from the other parent, the plans must pay in the following order:

- First**, the plan of the parent with custody of the child;
- Then**, the plan of the spouse of the parent with custody of the child;
- Finally**, the plan of the parent not having custody of the child.

However, if terms of a court decree state that one parent is responsible for the health care expenses of the child, and the insurance company has been advised of the responsibility, that plan is primary carrier over the plan of the other parent.

Medicare and COB

If you are covered by Medicare and have other group insurance as well, the COB rules are set by the Centers for Medicare & Medicaid Services (CMS). The following table provides general guidelines for Medicare and COB.

If you	Condition	Pays first	Pays second
Are age 65 and older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age (as long as the policy has not been converted to a supplemental policy)	The employer has less than 20 employees	Medicare	Group health plan
	The employer has 20 or more employees	Group health plan	Medicare
Have an employer retiree plan and are age 65 or older or disabled age 65 or older	Eligible for Medicare	Medicare	Retiree Coverage
Are disabled and covered by a large group health plan from your work, or from a family member who is working	The employer has less than 100 employees	Medicare	Group health plan
	Employer has 100 or more employees	Large group health plan	Medicare
Have End-Stage Renal Disease and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months	Medicare	Group health plan
Are covered under worker's compensation because of a job-related injury or illness	Eligible for Medicare	Workers' compensation for worker's compensation related services	Medicare
Have black lung disease and are covered under the Federal Black Lung Program	Eligible for Federal Black Lung Program	Federal Black Lung Program for black lung related services	Medicare
Have been in an accident where no-fault or liability insurance is involved	Eligible for Medicare	No-fault or Liability insurance, for accident related services	Medicare
Are age 65 or over OR disabled and covered by Medicare and COBRA	Eligible for Medicare	Medicare	COBRA
Have End-Stage Renal Disease and COBRA	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months	Medicare	COBRA

In recent years, it has been our experience for some Employer Group Policies to covert the members full coverage to a supplemental policy automatically when the patient becomes Medicare eligible. This requires the Medicare Part B premium to be paid by the member. It also means that even though the member is working full time, their Medicare will be primary.



10.26



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

I received The University of Chicago OHCA's Notice of Privacy Practices.

Patient's Printed Name

Signature of Patient (or Personal Representative*)

_____, 20____
Date of Signature

Personal Representative's Name (Printed)

Relationship of Personal Representative

** The Personal Representative is the patient's decision maker if the patient cannot act for themselves. It can be the parent, legal guardian, health care surrogate, or other person.*

The University of Chicago Medical Center
5841 South Maryland Avenue, Chicago IL 60637

The University of Chicago Organized Health Care Arrangement or "OHCA." It applies to the health services you receive at the below entities:

- 1. The University of Chicago Medical Center (UCMC): including its nurses, residents, other staff, and volunteers;*
- 2. Portions of The University of Chicago that participate in or support the activities of health care: including its physicians, nurses, students, volunteers, and other staff.*

**AUTHORIZATION TO USE AND DISCLOSE
HEALTH INFORMATION**

If the information is about a Mental Illness, Developmental Disability, HIV/AIDS Testing or Treatment, Communicable Disease, Venereal Disease, Alcohol or Drug Abuse, Abuse of an Adult with a Disability, Sexual Assault, Child Abuse or Neglect, or Genetic Testing, then the patient must sign the Specific Consent Attachment.

A patient label may be placed here:

Patient's Name: _____
Last First Middle

Medical Record Number: _____

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____

The UC Organized Health Care Arrangement (or **UC OHCA**) consists of University of Chicago Medical Center (UCMC) and certain activities of the University of Chicago including the physicians.

PURPOSE: When I sign this Authorization, I will allow the UC Organizations to disclose the health information listed below for the following purpose [*Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization*]:

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes:

RECIPIENT: The following is the name of person or the class of persons to whom the UC Organizations may disclose my health information:

The address of the recipient or where my health information will be delivered is:

I understand that the UC Organizations *will/will not (circle one)*, directly or indirectly, receive any items of value from any third party in connection with the use or disclosure of the health information.

TERM: This Authorization will remain in effect:

- From the date of this Authorization until the following date: _____, 200__.
- Until the purpose is fulfilled.
- Until the following event occurs (e.g. after the specific fundraising program is over):

Other (e.g. no expiration): _____.

Note: The Term for mental health records must be stated—you may not use "no expiration."

***Provide a copy of signed Authorization to Patient**

SPECIFIC CONSENT ATTACHMENT

Patient's Name: _____

Last

First

Middle

Medical Record Number: _____

SPECIFIC CONSENT

By checking any of the boxes next to a category of confidential information listed below, I specifically authorize the use and/or disclosure of the category of confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability
- Psychotherapy Notes (which are not part of the official medical record)
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Communicable Diseases
- Information about Venereal Disease(s)
- Information about Substance (i.e., alcohol or drug) Abuse
- Information about Abuse of an Adult with a Disability
- Information about Sexual Assault
- Information about Child Abuse and Neglect
- Information about Genetic Testing

I have read and understand the terms of this Attachment and I have had a chance to ask questions about the use and disclosure of the confidential information. I authorize each UC Organization to use or disclose the confidential information checked above in the manner described above.

Signature of Patient or Personal Representative

Date

Name of Personal Representative (if applicable)*

Relationship to Patient

Witness' Signature required for release of information about a mental illness or developmental disability

Signature of Witness: _____