LAKE NORMAN HEMATOLOGY ONCOLOGY SPECIALISTS

170 Medical Park Road, Suite 101, Mooresville, NC 28117
10030 Gilead Road, Suite 350, Physicians Plaza, Huntersville, NC 28078
Phone: (704)7993946 – Fax (704)799-3956
www.lakenormanoncology.com

Huntersville • Mooresville

MR # _____
Appt. Date: _____

NEW PATIENT INFORMATION FORM

○ **Richard Krumdieck, M.D.** ○ **David A. Eagle, M.D.** ○ **Timothy Kuo, M.D.**

Patient Name _____
Last First Middle Initial

Address _____

City _____ **State** _____ **Zip** _____

Employed: ○ **Yes** ○ **No** **Employer**_____ **Employer Phone** _____

Home Phone_____ **Cell Phone** _____ **Preferred Number:** ○ **Home** ○ **Cell**

Email: _____ **Would you like to opt out of practice emails?** ○ **Yes** ○ **No**

Date of Birth _____ **Social Security #** _____

Maiden Name/Preferred Nick Name _____ **Marital Status:** ○ **Married** ○ **Single** ○ **Other**

Referring Physician _____ **Primary Physician** _____

Reason for Referral _____

Emergency Contact _____ **Relationship** _____

Emergency Home Phone _____ **Emergency Work Phone** _____

Preferred Pharmacy _____ **Location** _____

Phone _____ **Fax** _____

Insurance Information:

Primary Ins. Co _____ **Secondary Ins. Co.** _____

Insurance ID# _____ **Insurance ID#** _____

Group # _____ **Group #** _____

Employer _____ **Employer** _____

Policyholder's Name_____ **Policyholder's Name** _____

Policyholder's Date of Birth _____ **Policyholder's Date of Birth** _____

Policyholder's Social Security # _____ **Policyholder's Social Security #** _____

I give consent for Lake Norman Hematology Oncology Specialists staff to perform routine office procedures, services, treatment, examinations and diagnostic procedure required during my visit. I hereby authorize Lake Norman Hematology Oncology Specialists to furnish and/or receive my medical records to/from insurance carriers and any physician assisting in my care concerning my illness and treatments. I hereby assign Lake Norman Hematology Oncology Specialists all payments for medical services rendered to myself or dependents. I understand that these authorizations will remain in effect as long as my dependent or I remain a patient. I understand that I will be responsible for all charges not covered by insurance.

Patient Signature: _____ **Date:** _____
Relationship if Other Than Patient: _____

LAKE NORMAN HEMATOLOGY ONCOLOGY SPECIALISTS

Current Medications

Patient Name _____ D.O.B. _____ MR# _____

1. Current Medications:
List the medications you are currently taking (Prescription and non-Prescription)

Medication Name	Dose	Times Per Day

2. Allergies
List any medications or other substances to which you are allergic (i.e. pollen, food, tape, latex, etc.)

Medication or Substance	Allergic Reaction

3. Past Medical History:
List any medical illnesses that you have or have had in the past (i.e. heart attack, heart failure, high blood pressure, emphysema, etc.)

Illness	Date (Approximate Month/Year)

(Medical History Continued) **MR # _____**

List any prior surgeries or procedures

Surgery/Procedure	Date (Approximate Month/Year)

- **When was your last Colonoscopy? _____**
- **When was your last Mammogram? _____**

Reproductive History for Women:

- **Approximately at what age did you begin having periods? _____**
- **How many children have you had? _____**
- **How old were you when your first child was born? _____**
- **Have you had any miscarriages? ○ Yes ○ No If yes, how many? _____**
- **Have you gone through menopause? ○ Yes ○ No If yes, approximately how old were you? _____**
- **Have you had a hysterectomy? ○ Yes ○ No**
- **If yes, how old were you? _____ Were your ovaries removed? ○ Yes ○ No**
- **Have you at any time taken hormone replacement therapy? ○ Yes ○ No**
- **If yes, what did you take and for how long? _____**

4. Family History

List any major illnesses that run in your family.

Illness	Relationship

Habits

- **Do you smoke or have you ever smoked cigarettes? ○ Yes ○ No**
- **If yes, how much and for how long? _____**
- **If you have quit smoking, when did you quit? _____**
- **Do you use other tobacco products? _____**
- **Do you drink alcohol? ○ Yes ○ No ● If yes, how much and how often? _____**

LAKE NORMAN HEMATOLOGY ONCOLOGY SPECIALISTS

Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____

Lake Norman Hematology Oncology Specialists are authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
○ **Voice Mail**	○ **Results of lab tests/x-rays** ○ **Other_____**
○ **Spouse (Provide Name & Phone Number)** _____	○ **Financial** ○ **Medical as follows: _____**
○ **Parent (Provide Name & Phone Number)** _____	○ **Financial** ○ **Medical as follows: _____**
○ **Other (Provide Name, Number and Relationship)** _____	○ **Financial** ○ **Medical as follows: _____**

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative **Date**

Description of Personal Representatives Authority (attach necessary documentation)

Lake Norman Hematology Oncology Specialists
Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name: _____

Patient Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature **Date**

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ○ **An emergency existed & a signature was not possible at this time.**
- ○ **The individual refused to sign.**
- ○ **A copy was mailed with a request for a signature by return mail.**
- ○ **Unable to communicate with the patient for the following reason:** _____

  _____
- ○ **Other:** _____

  _____

Prepared By: _____

Signature: _____

Date: _____

Lake Norman Hematology Oncology Specialists

Richard Krumdieck, MD **David Eagle, MD** **Timothy Kuo, MD**

Regarding Patient:

Last Name First Name MI

Street Address

City State Zip Code

Date of Birth **Social Security Number**

For Office Use:

Information From:

Name (HealthCare Provider)

Street Address

City, State, Zip Code

Information Released to:

Lake Norman Oncology
170 medical Park Road, Suite 101
Mooresville, NC 28117
Phone (704)799-3946 Fax (704)799-3956

This information shall include the following:

__ Office Notes **__ Laboratory Reports**
__ Radiology Reports **__ Pathology Reports**
__ ECG/EEG **__ Entire Record**
__ Other (Specify) _____

NOTICE: This authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of visits, and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted diseases, including HIV/AIDS information. Such records will be disclosed unless specified. Information to exclude is listed below:

Exclusions: _____

Signature of Patient/Legal Authority: _____

Lake Norman Hematology Oncology Specialists

NOTICE OF SEPARATE BILLING

Your provider may order laboratory services for you during your visit. Although the services are performed in this facility, some labs are sent off site to be processed. If there are any monies owed from those services, you will receive a separate bill from that lab.

Billing for laboratory services is done through LabCorp, Miraca, or Myriad; not through this office. Please be advised that some insurance companies mandate where your lab tests can be performed. The physician in this facility may be in-network with your insurance company but these laboratories may not.

Some insurance companies may also apply lab charges to your deductible. If you have questions as to whether your charges will be managed in this manner, please consult with your insurance company.

Below are the billing phone numbers for each off site laboratory:

LabCorp: 800-762-4344
Miraca: 888-344-1160
Myriad: 800-469-7423

Thank you for choosing Lake Norman Hematology Oncology Specialists

Patient Signature_____ Date _____