Christopher T. Soprenuk, M.D., P.A.

Hematology - Oncology

Today's Date: _____

NEW PATIENT HISTORY FORM

(Please Print in Blue/Black Ink)

Patient Name: _____

DOB: ___/___/____ **SS#:**_____ ◯**Male** ◯**Female**

Address: _____**City:** _____**State:** _____**Zip Code:** _____

Alternate Address: _____

Home: (____) _____**Mobile:** (____) _____**Email:** _____

May we leave a message on your voicemail? ◯Yes ◯No May we email you? ◯Yes ◯No

Notification Preference for Reminders: ◯Home ◯Mobile ◯Other _____

Emergency Contact Name: _____

Phone: (____) _____**Relationship:** _____

Marital Status: ◯Married ◯Single ◯Divorced ◯Widowed

Ethnicity/Race: ◯White ◯Hispanic/Latino ◯Black/African American ◯Native American ◯Asian/Pacific Islander

Advanced Directive: ◯ Power of Attorney ◯ Living Will ◯ DNR (Do Not Resuscitate)

Primary Care Physician: _____**Phone:** (____) _____

Referring Physician (if different): _____**Phone:** (____) _____

Please list any additional Physicians you see: (include phone #)

_____Phone: (____) _____

_____Phone: (____) _____

_____Phone: (____) _____

_____Phone: (____) _____

Local Pharmacy Name: _____Phone: (____) _____

Pharmacy Address: _____

Mail Order Pharmacy Name: _____**Phone:** (____) _____

Pharmacy Address: _____

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NEW PATIENT MEDICAL HISTORY FORM

(Please Print in Blue/Black Ink)

Patient Name: _____

Your treatment can be affected by any medication that you take, and it is important that your physician has updated and correct medication information.

Medication List (if you have more than 8 medications bring in an attached copy)

Medication	Dose	Frequency	Ordering Physician

Drug Allergies (list all medication allergies)

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Are you allergic to?

◯Iodine ◯Latex ◯Shellfish ◯CT Scan Dye/IV Contrast ◯Eggs ◯Peanuts ◯NKA

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NEW PATIENT MEDICAL HISTORY FORM

(Please Print in Blue/Black Ink)

Patient Name: _____

Reason for Visit: _____

Medical History (check all that apply to you, currently or in the past)

◯Anemia	◯Asthma	◯Lupus-Autoimmune
◯Bleeding Disorder	◯Chronis Lung (COPD)	◯Reynaud's Syndrome
◯Blood Clots	◯Pneumonia/Bronchitis	◯Rheumatoid Arthritis
◯Blood Disorder	◯TB (Tuberculosis)	◯Osteoarthritis
◯Frequent Infections	◯Sleep Apnea	◯Chronic Back Pain
◯HIV /AIDS	◯Colon Polyps	◯Osteoporosis
◯Diabetes	◯Crohn's Disease	◯Fracture
◯Thyroid Disease	◯Diverticulitis	◯Stroke
◯High Blood Pressure	◯Irritable Bowel Syndrome	◯Neuropathy
◯High Cholesterol	◯Ulcerative Colitis	◯Parkinson's Disease
◯Artrial Fibrillation	◯Stomach Ulcers	◯Paralysis
◯Congestive Heart Failure	◯GERD	◯Seizures
◯Heart Attack	◯Hiatal Hernia	◯Migraines
◯Heart Disease	◯Gallstones	◯Shingles
◯Rheumatic Fever	◯Cirrhosis of Liver	◯Glaucoma/Cataracts
◯Heartburn/Reflux	◯Hepatitis A/B/C	◯Hearing Loss
◯Heart Murmur	◯Pancreatitis	◯Cancer
◯Irregular Heart Beat	◯Kidney Stone	◯Leukemia
◯Peripheral Vascular Diseases	◯Kidney Disease/Failure	◯Lymphoma
◯Freq Urinary Tract Infections	◯Anxiety	◯Depression
◯Enlarged Prostate	◯Drug Use	◯Problems with Anesthesia

Details of Medical History: _____

_____

_____

_____

_____

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NEW PATIENT MEDICAL HISTORY FORM

(Please Print in Blue/Black Ink)

Patient Name: _____

Social History:

Tobacco Use (present &/or past)

◯Never Smoked

◯Quit Smoking When? _____ How many years smoking? _____

◯Currently Smoking ◯Cigarettes ◯Pipe ◯Cigars How many packs? ____/day How many yrs?_____

◯Chewing Tobacco How much? _____/day How many yrs? _____

Alcohol Use

◯Non Drinker

◯Beer How much? _____/day _____/week _____/month

◯Wine How much? _____/day _____/week _____/month

◯Liquor How much? _____/day _____/week _____/month

Family Medical History (indication any family members with cancer, blood disease, or other disease. If deceased, cause of death)

	Name	Age	Disease	If deceased, cause of death
Father				
Mother				
Sibling's				

_____

_____

_____

Surgical History (please list any past surgical history of what, when and where)

_____

_____

_____

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(Please Print in Blue/Black Ink)

Patient Name: _____ DOB: _____

Social Security Number: _____

Release To:

Dr. Christopher T. Soprenuk

9846 US Hwy 441, Leesburg, FL 34788

P: (352) 728-1886

F: (352) 728-1024

Release From:

_____

_____

_____

_____

Please release all information for the purpose of review and examination and further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitation as listed below:

Records Requested: ◯X-ray Reports ◯Lab Reports ◯Consultation Notes ◯Office Notes ◯Pathology Reports ◯Operation Notes ◯Procedure Notes ◯All

Dates of Records Request: From: _____ to: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Services Department/Medical Records Staff. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, there authorization will expire on the following date, event, or condition (not to exceed 6 months): _____. If I fail to specify an expiration date, event or condition this authorization will expire 6 months from the date signed.

I understand that by authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I give special permission (by initialing on the lines below) to release any information regarding:

_____Substance Abuse _____HIV/AIDS Information _____Psychiatric/Metal Information

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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RELEASE OF INFORMATION

(Please Print in Blue/Black Ink)

I, _____, give permission to Dr. Soprenuk and his employees to release information pertaining to my health to the following people:

- _____ Name _____ Relationship to Patient
- _____ Name _____ Relationship to Patient
- _____ Name _____ Relationship to Patient

This information may include but not limited to test results, status of my current health, and plans for future tests.

This release of information will valid until it is revoked by me.

_____ _____

Patient Signature Date

_____

Social Security Number

_____

Date of Birth

_____ _____

Witness Signature Date

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ACKNOWLEDGMENT FORM

(Please Print in Blue/Black Ink)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of out Notice may change. If we change our Notice, you may obtain a revised copy by requesting it in the office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do we are bound by agreement.

By signing this form, you consent to our use and disclose of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____

Patient Signature Date

_____

Patient Name (Print)

_____ _____

Witness Signature Date