ANN M WIERMAN MD, LTD
3150 N Tenaya Way Suite 200
Las Vegas, NV 89128
Phone: (702) 749-3700
Fax: (702) 749-3706

NEW PATIENT REGISTRATION FORM

DATE:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT INFORMATION

Name: (last, first, middle)	**SSN:**
DOB: **SEX:**	
Address:	
City **State** **Zip Code**	
Home Phone #:	**Work Phone #:**
Cellular #:	**Pref. Communication:** **Fax #:**
Email:	
May we email you? ___Yes _____No **May we leave message on your voice mail?**	
Race: __American Indian/Alaska native __Asian __Black African American __Multiracial __Native Hawaiian __Pacific Islander __Unreported/Refused to Report __White	
Ethnicity: __Hispanic/Latino __ Non-Hispanic/Latino __ Unreported/Refused to Report	**Preferred Language:** **Interpreter?**

RESPONSIBLE PARTY INFORMATION

Responsible party: ☐ Self ☐ Guarantor **Responsible party name:**	**DOB:**
Responsible party Social Security Number:	**Phone Number:**

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	**Phone Number:** **Relationship to the patient:**

GENERAL INFORAMTION

Name of Employer:	**Work Phone:**	**Occupation:**
Primary Care Physician:	**Phone #:**	**Fax #:**
Pharmacy:	**Pharmacy Address:**	
Pharmacy Phone #:	**Fax #:**	
Referring Physician & Contact Info:		

Please list any additional Physicians you see:

Power of Attorney (If applicable):
Name: **Relation to patient:** **Phone #:**

Patient's Initial:

ANN M WIERMAN MD, LTD
3150 N Tenaya Way Suite 200
Las Vegas, NV 89128
Phone: (702) 749-3700
Fax: (702) 749-3706

INSURANCE INFORMATION
(Please Print)

Today's Date:
Patient's Name:

LAST FIRST
MIDDLE

Primary Insurance:	
Are you the main policy holder? YES NO	Name of primary policy holder:
Policy number:	Effective Date:
Group number:	Policy holder's SS#:
Patient's relationship to subscriber:	**DATE OF BIRTH:** (Please indicate)

Secondary Insurance:	
Are you the main policy holder? YES NO	Name of primary policy holder:
Policy number:	Effective Date:
Group number:	Policy holder's SS#:
Patient's relationship to subscriber:	**DATE OF BIRTH:** (Please indicate)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ann M Wierman MD, LTD. Or insurance company to release any information required to process my claims.

_____ _____
Patient/Guardian Signature Date

Patient's Initial:

ANN M WIERMAN MD, LTD
3150 N Tenaya Way Suite 200
Las Vegas, NV 89128
Phone: (702) 749-3700
Fax: (702) 749-3706

Patient Name: _____ **DOB:** _____

PROVIDING QUALITY CARE TO ALL OF OUR PATIENT IS OUR MISSION

Ann M. Wierman MD. Ltd. Is committed to providing you with the highest quality of care. In order to maintain transparency regarding financial obligation, we require all patients to acknowledge their responsibility for payment of services rendered, regardless of insurance coverage.

As an Oncology and Hematology specialist, we know that modern Oncology and Hematology care may be expensive. We will work with you and your insurance company to provide the most effective treatment options at the minimal cost to you.

Ann M. Wieman MD., LTD provides verification and review of your insurance benefits. If you feel your estimated cost is not affordable, please inform the office immediately before treatment starts.

Our office requires that you provide your current health insurance identification card and ID to all appointments; complete all required paperwork in a timely manner.

Patient Acknowledgment
I understand that it is my responsibility to be aware of my insurance benefits and limitations. I acknowledge that:

1. I am responsible for any amount not covered by my insurance, including but not limited to copayments, deductibles, and coinsurance.
2. I am responsible for verifying my insurance coverage and benefits prior to receiving services.
3. If my insurance denies payment for services rendered, I will remain financially responsible for the full amount due.
4. I agree to pay any outstanding balance within the timeframe specified by Ann M. Wierman Md. Ltd.
5. In the event that my account is sent to collections due to non-payment, I understand that I may be responsible for additional fees incurred during the collection process.

By signing below, I acknowledge that I have read and understood this Financial Responsibility Acknowledgment.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Patient's Initial:

ANN M WIERMAN MD, LTD
3150 N Tenaya Way Suite 200
Las Vegas, NV 89128
Phone: (702) 749-3700
Fax: (702) 749-3706

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ DOB: _____

Previous Name: _____Social Security#:_____

I request and authorize _____
to release my healthcare information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I, the undersigned, hereby authorize the release of my protected health information as described below:

Specific Information to be Released:

_____ Entire medical record

_____ Specific dates of service: _____

_____ Specific information (e.g., lab results, diagnosis, treatment plans):
_____
_____

- Other (please specify): _____

I understand that my health information is protected by federal and state privacy laws. I authorize the release of my healthcare information as indicated above.

Patient Signature: _____Date: _____

Patient's Initial:

PATIENT NAME:

REASON FOR THE VISIT:

Medical History: (Check all that apply to you currently or in the past)		
	☐ None	☐ Hiatal Hernia
	☐ Anemia	☐ Gallstones
	☐ Bleeding Disorder	☐ Cirrhosis of Liver
	☐ Blood Clots	☐ Hepatitis ☐ A ☐ B ☐ C When?
	☐ Blood Disorder	☐ Pancreatitis
	☐ Frequent Infections	☐ Kidney Stone
	☐ HIV / AIDS	☐ Kidney Disease / Failure
	☐ Diabetes	☐ Frequent Urinary Tract Infection
	☐ Thyroid Disease	☐ Enlarged Prostate
	☐ High Blood Pressure	☐ Lupus-Autoimmune
	☐ High Cholesterol	☐ Raynaud's Syndrome
	☐ Atrial Fibrillation	☐ Rheumatoid Arthritis
	☐ Congestive Heart Failure	☐ Osteoarthritis
	☐ Heart Attack-MI	☐ Chronic back pain
	☐ Heart Disease	☐ Osteoporosis
	☐ Rheumatic Fever	☐ Fracture
	☐ Heartburn / Reflux	☐ Stroke
	☐ Heart Murmur	☐ Neuropathy
	☐ Irregular Heart Beat	☐ Parkinson's Disease
	☐ Peripheral Vascular Disease	☐ Paralysis
	☐ Asthma	☐ Seizures
	☐Chronic Lung (COPD)	☐ Migraines
	☐ Pneumonia / Bronchitis	☐ Shingles
	☐ TB (Tuberculosis)	☐ Glaucoma / Cataracts
	☐ Sleep Apnea	☐ Hearing loss
	☐ Colon Polyps	☐ Cancer Where? Doctor?
	☐ Crohn's Disease	☐ Leukemia
	☐ Diverticulitis	☐ Lymphoma
	☐ Irritable Bowel Syndrome	☐ Depression
	☐ Ulcerative Colitis	☐ Drug use
	☐ Stomach Ulcer	☐ Problem with Anesthesia
	☐ GERD / Heartburn	☐ Other

Details of Medical History:

Patient's Initials:

PATIENT NAME:			
CANCER HISTORY			
Date Diagnosed:			
Type of Cancer:			
Treatment:			
Treating Physician:			
PAST SURGICAL HISTORY			
☐ Coronary Bypass	Date:		
☐ Angioplasty	Date:		
☐ Pacemaker	Date:		
☐ Cardiac Valve Surgery	Date:		
☐ Hemorrhoidectomy	Date:		
☐ Prostate operation	Date:		
☐ Hernia Repair	Date:		
☐ Tonsillectomy	Date:		
☐ Mastectomy	Date:		
☐ Lumpectomy	Date:		
☐ Knee Replacement	Date:		
☐ Rotator Cuff Repair	Date:		
☐ Cataract	Date:		
☐ Gallbladder Surgery	Date:		
☐ Hysterectomy	Date:		
☐ Prostatectomy	Date:		
☐ Appendectomy	Date:		
☐ Hip Replacement	Date:		
SOCIAL HISTORY			
Tobacco Use: (Present or Past)			
☐ Never Smoked	☐ Marijuana		
☐ Chewing Tobacco			
☐ Quit Smoking	When?	How many year/s?	How many packs?
☐ Currently Smoking	☐ Cigarettes ☐ Pipe ☐ Cigars	How many year/s?	How many packs?
Alcohol History: (Present or Past)			
☐ Non Drinker			
☐ Beer	Number of bottles per _____ ☐ Day ☐ Week ☐ Month		
☐ Wine	Number of bottles per _____ ☐ Day ☐ Week ☐ Month		
☐ Liquor	Number of bottles per _____ ☐ Day ☐ Week ☐ Month		
Patient's Initials:			

PATIENT NAME:		
Influenza Shot: ☐ Yes ☐ No	Date of last Influenza Shot:	
Pneumococcal Shot: ☐ Yes ☐ No	Date of last Pneumococcal Shot:	
Shingles Shot: ☐ Yes ☐No	Date of last Shingles Shot:	
Last EGD: ☐ Yes ☐ No	Date of last EGD:	
Colonoscopy: ☐ Yes ☐ No	Date of last Colonoscopy:	Findings:
Sigmoidoscopy: ☐ Yes ☐ No	Date of last Sigmoidoscopy:	Findings:
Bone Density: ☐ Yes ☐ No	Date of last Bone Density:	Findings:
Pelvic Exam: ☐ Yes ☐ No	Date of last Pelvic Exam:	Findings:

FAMILY MEDICAL HISTORY (Indicate any family members with cancer, blood disease, or other disease)

	Age	Disease	If deceased, cause of death
Grandfather			
Grandmother			
Father			
Mother			
Siblings			
Children			

In your opinion, are there any diseases that run in your family? ☐ Yes ☐ No
Please list:

OB/GYN HISTORY	
How many times have you been pregnant?	How many live births have you had?
Your age at the birth of your first child?	Any history of miscarriages or abortions?
Did you breast feed? ☐ Yes ☐ No	If yes, how long did you breast feed?
Are you using birth control? ☐ Yes ☐ No	If yes, please include type:
Any complications during pregnancy? ☐ Yes ☐ No	
Are you sexually active? ☐ Yes ☐ No	
Do you wish to become pregnant? ☐ Yes ☐ No	
How old were you when you began to menstruate?	
Are you still having periods? ☐ Yes ☐ No	
If yes, first day of your last period:	
If no, how old were you when you stopped having periods?	
Are you experiencing of the below symptoms?	
☐ Menstrual Pain	
☐ Bleeding between periods	
☐ Spotting between periods	
☐ Excessive bleeding	
Date of last Mammogram:	
Date of last PAP Smear:	
Have you had an abnormal PAP test? ☐ Yes ☐ No	
If yes, please list date and type of any treatment(s) received:	
Patient's Initials:	

PATIENT NAME:		
REVIEW OF SYMPTOMS (Please check any current symptoms you have)		
General	**Cardiovascular**	**Allergies/Immunology**
☐ Weight, Loss How much:	☐ Chest Pain/Angina Pectoris	☐ History of Chronic Infections
☐ Fever, Max temperature:	☐ Palpitation/ Heart Murmur	☐ History of Allergies
☐ Chills	☐ Irregular Heart Beat Pressure	**Endocrine**
☐ Night Sweats	**Respiratory**	☐ Heat or Cold Intolerance
☐ Fatigue	☐ Chronic or Frequent Cough	☐ Excessive Skin Dryness
Eyes	☐ Bloody Sputum	☐ Excessive Thirst or urination
☐ Wear Glasses/Contact Lenses	☐ Shortness of Breath	☐ Weight Problem
☐Blurred Vision	**Genitourinary**	☐Hot Flashes
☐ Double Vision	☐ Kidney Stones	**Breast**
Ears, Nose, Throat	☐ Pelvic Pain	☐ Skin Reaction
☐ Hard of hearing or deaf	☐ Incontinence	☐ Breast Lump/Mass
☐ Ringing in Ears	☐ Burning or Pain on Urination	☐ Nipple Discharge
☐ Enlarged lymph nodes	**Musculoskeletal**	☐ Skin Cancer
☐ Chronic Sinus Problem	☐ Joint Pain/ Arthritis	☐ Breast Pain
☐ Sore Throat	☐ Muscle or Joint Weaknesses	☐ Skin Lesion
☐ Mouth Pain/Sores	☐ Back Pain	☐ Vaginal Discharge
Changes/Difficulty	☐ Bone Pain	☐ Menstrual Irregularity or Abnormal Bleeding
☐ Taste	☐ Muscle Aches	**Blood**
☐ Smell	**Neurological**	☐ Anemia
☐ Voice	☐ Numbness/Tingling	☐ Low White Cells
Gastrointestinal	☐ Arm or Leg Weakness	☐ Too many CBC
☐ Difficult of Painful Swallowing	☐ Light-Headed/Dizzy/Fainting Spells	☐ Low Platelets
☐ Abdominal Pain	☐ Headache	☐ Too many Platelets
☐ Nausea	☐ Tremors	☐ Too many Red Cells
☐ Vomiting	**Skin**	☐ CLL Leukemia
☐ Heartburn	☐ Rashes or Itching	☐ CML Leukemia
☐ Indigestion	☐ Change in skin color or Moles	☐ AML Leukemia
☐Lump or Sensation in Throat	☐ Varicose Veins	☐ ALL Leukemia
☐ Food Sticking	☐ Skin Cancer	☐ MDS
☐ Bloating	**Psychiatric**	☐ Hypergammaglobulinemia
☐ Belching	☐ Anxiety/Agitation	☐ MGUS
☐ Diarrhea	☐ Depression	☐ Multiple Myeloma
☐ Constipation	☐ Crying for no reason	☐ Nose Bleeds
☐ Rectal Bleeding	☐ Insomnia	☐ Blood in Urine
☐ Black or tarry Stools	☐ Alcoholism	☐ Blood in Stool
☐ Hidden Blood in Stool	☐ Drug Problem (Now/Past)	☐ Hemorrhoids
☐ Excessive Rectal Gas/Flatus	**Hematologic**	☐ Black Stool
☐ Loss of Stool/Fecal Accident	☐ Easy Bruising	
☐ Poor Appetite	☐Gum or Nose Bleeding	
☐ Jaundice	☐ Blood Transfusion in past	
Patient's Initials:		

PATIENT NAME:

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

DRUG ALLERGIES (List all medication allergies)

Medication	Reaction

Are you allergic to: ☐ Iodine ☐ Latex ☐ Shellfish ☐ CT Scan Dye/IV Contrast ☐ Eggs ☐ Peanuts

☐ Other:

Type of Reaction:

PHARMACY:

ADDRESS:

PHONE:

LIST ALL MEDICATIONS (including non-prescription that you are currently taking)

Medication	Dose	Frequency	Ordering Physician

Patient's Initial: