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WPPA of Larchmont
Hematology & Oncology
2345 Boston Post Road
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Patient Demographics

Patient's Last Name___________________________First Name _______________________Middle Initial _______

SSN_____________________________Date of Birth_______________Age___________Gender F M

Address_____________________________Apt. #_______City________________________State_____Zip ______

Race:
☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _________________

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone_____________________________________Day Phone ___________________________________

Email Address____________________________________Cell Phone ___________________________________

Employer______________________________________Occupation_______________________________☐Retired?

Employer Address ____

Emergency Contact_______________________________/____________________Phone _______________________
Name Relationship

Primary Care Physician Name:____Phone:__________________________

Referring Physician Name:____Phone: _________________________

Pharmacy Name:____Phone: _______________________________

Pharmacy Address: ____

Primary Insurance Coverage: ____

Policy Holder Name:______________________________________SSN:_____________________DOB:___________

Secondary Insurance Coverage: ____

Policy Holder Name:_____________________________________SSN:_______________________DOB: ___________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature____Date________________

Responsible Party Name____Relationship ______________

Patient History Form

Name:_______________________________________**Date of Birth:** ____________________

Reason for Visit:

____

____

Please List All Current Medications ☐ **Not Currently Taking Any Medications**

Medication Name	Dosage	How Often Taking	Medication Name	Dosage	How Often Taking

Allergies (e.g. medication, latex, egg) ☐ **No Known Allergies**

Allergen	Type of Reaction	Allergen	Type of Reaction

Past Medical History

☐	Anxiety Disorder	☐	Diverticulitis	☐	Kidney Disease
☐	Arthritis	☐	Fibromyalgia	☐	Kidney Stones
☐	Asthma	☐	Gout	☐	Leg/Foot Ulcers
☐	Bleeding Disorder	☐	Has Pacemaker	☐	Liver Disease
☐	Blood Clots (or DVT)	☐	Heart Murmur	☐	Osteoporosis
☐	Coronary Artery Disease	☐	Hiatal Hernia	☐	Polio
☐	Claustrophobia	☐	Reflux Disease	☐	Pulmonary Embolism
☐	Diabetes- insulin	☐	HIV or AIDs	☐	Ulcers
☐	Diabetes- Non-insulin	☐	High Cholesterol	☐	Stroke
☐	Dialysis	☐	High Blood Pressure	☐	Tuberculosis
☐	DVT	☐	Overactive Thyroid	☐	Other

Cancer History

Cancer Type	Year Diagnosed	Treatment (e.g. chemo, radiation)	Year Treated

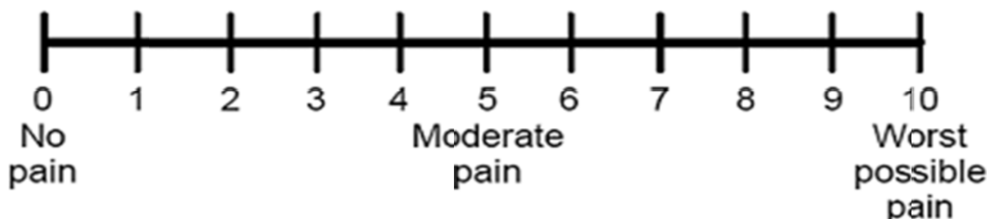
Patient Name:____Date of Birth: _______________

Past Surgical History		
Please list all past surgical procedures:		☐ **No Surgical History**
Surgical Procedure	**Year**	**Surgeon**

Social History		
Smoking Status:		
Smoking Tobacco Use History (all patients age 13 and older):		If there is a history of tobacco use: Years Used: __________ Usage Per Day:__________ Age Stopped:____________
☐ Never Smoker	☐ Current Every Day Smoker	
☐ Former Smoker	☐ Current Some Day Smoker	
☐ Unknown if Ever Smoker	☐ Smoker Current Status Unknown	
Alcohol & Caffeine Use:		
Do You Consume Alcohol? ☐ No ☐ Yes ☐Former Frequency:_________Amount: _________		
Do You Consume Caffeine? ☐ No ☐ Yes Type:___________Caffeine per day: _____________________		
Fall Risk:		
Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: __________		
Did the fall(s) result in injury? ☐ Yes ☐ No		

Pain Scale:

Please indicate (circle) your current pain scale in relation to your current condition:



Patient Signature:____Date: __________________

Patient Representative Signature:______________________________ Relationship: _______________