Wahid T. Hanna, MD

Patient Information Form

Patient Last Name	First Name	Middle	Maiden

Street Address	Home Telephone *(incl area code)*	Cell Phone *(include area code)*

City	State	Zip	Work Telephone *(include area code)*

Date of Birth	Social Security Number	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer	How long employed?	Occupation

Employer Address *(include Street, City, State, Zip)*

Spouse's Name (Parent if patient is a minor)	Spouse's Employer (Parent, if minor)	Spouse's Work Telephone (Parent, if minor)

Other Close Relative Not Living With You for Emergency Contact	Home Telephone *(include area code)*	Relationship

Person Responsible for Payment	Relationship	Area Code	Telephone Number

Street Address	City	State	Zip

Primary Insurance	Policy/Certificate Number	Group Number	Effective Date

Policy Holder's Name	Policy Holder's Gender ☐ Male ☐ Female	Policy Holder's Date of Birth	Policy Holder's Social Security #

Policy Holder's Address *(include Street, City, State, Zip)*

Secondary Insurance	Policy/Certificate Number	Group Number	Effective Date

Policy Holder's Name	Policy Holder's Gender ☐ Male ☐ Female	Policy Holder's Date of Birth	Policy Holder's Social Security #

Policy Holder's Address *(include Street, City, State, Zip)*

Other Insurance	Policy/Certificate Number	Group Number	Effective Date

Policy Holder's Name	Policy Holder's Gender ☐ Male ☐ Female	Policy Holder's Date of Birth	Policy Holder's Social Security #

Policy Holder's Address *(include Street, City, State, Zip)*

Please read:
All charges are due at the time of services. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

Insurance Authorization Assignment

I request that payment of authorized Medicare / Other Insurance Company benefits be made either to me or on my behalf to **WAHID T. HANNA, MD, PC** for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/Other Insurance Company claim. I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 S.C. 3801-312 provides penalties for withholding this information.)

Signature	Date
X	X

WAHID T. HANNA, MD, PC

GENERAL MEDICAL INFORMATION

Date		
Patient Last Name	First Name	Middle or Maiden
Date of Birth	Social Security Number	

Has any member of your family been treated by our practice? ☐Yes ☐No
If yes, please list name(s)

PHYSICIANS YOU SEE

Primary Care Physician *(include First and Last names)*	Area Code	Telephone Number
Primary Care Physician Address		

Other Physicians

First Name	Last Name	City	Specialty

I hereby authorize Wahid T. Hanna, MD, PC to release any information including the diagnosis and records of any treatment, examination or testing rendered to me, to the above named physicians.

Patient (or Guardian) Signature _____ Date _____

Are you allergic to any medications?	☐Yes	☐No
If yes, please list:		
Are you allergic to CT or scan dye?	☐Yes	☐No
Are you allergic to seafood?	☐Yes	☐No
Are you diabetic?	☐Yes	☐No
If yes, do you take glucophage?	☐Yes	☐No
Do you have a pacemaker or any metal implanted in your body?	☐Yes	☐No

UNIVERSITY OF TENNESSEE MEDICAL CENTER
1934 ALCOA HIGHWAY BLDG D SUITE 170♦ KNOXVILLE, TN 37920
(865) 305-8684

1592

LABEL

Outpatient Home Medication List

Name MR# PHYSICIAN DATE

Allergies: ☐ No Known Drug Allergies

Drug Allergy/Reaction :	Pharmacy :
	Pharmacy Phone:

Any changes need signature, date, & time

Prescription, Over-The-Counter, Herbal, Patches, Inhalers, Total Parenteral Nutrition, etc...

☐ No Current Medications

Drug Name	Dose	Route	Frequency	Indication	Sign/Date/Time

Information source(s): ☐ patient recall ☐ patient medication list ☐ drug container from home ☐ other:

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

Sign/Date/Time_____ Sign/Date/Time_____ Sign/Date/Time_____

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Medical Review of Systems

Name:_____

Please answer all questions by circling your response.

GENERAL:

Has your appetite been decreased?	Yes	No
Have you lost weight?	Yes	No
If yes, how much?_____lbs.		
In what period of time?_____ months		
Any difficulty sleeping	Yes	No
Do you have fevers?	Yes	No
Do you get cold easily?	Yes	No
Do you have shaking chills?	Yes	No
Do you have drenching night sweats?	Yes	No
Weakness, fatigue, easy tiredness?	Yes	No
Lumps, bumps, or swollen glands?	Yes	No
Unusual cravings (ice, nonfood items)	Yes	No
Previous Radiation treatment?	Yes	No
Previous Chemotherapy treatment?	Yes	No

HEENT:

Any recent change in vision?	Yes	No
Any ear disease, change in hearing?	Yes	No
Nose, sinus, throat problems?	Yes	No
Nosebleeds?	Yes	No

RESPIRATORY:

Any shortness of breath with activity?	Yes	No
Any shortness of breath at rest?	Yes	No
Any shortness of breath at night?	Yes	No
Do you have a cough?	Yes	No
Coughing up sputum?	Yes	No
Coughing up blood?	Yes	No
Wheezing or asthma?	Yes	No
Hoarseness?	Yes	No

CARDIOVASCULAR:

Chest pain?	Yes	No
Heart disease?	Yes	No
Heart murmur?	Yes	No
Palpitations or fluttering heart?	Yes	No
Irregular heart beat?	Yes	No
Ankle edema or swelling?	Yes	No

GASTROINTESTINAL:

Do you get full easily?	Yes	No
Difficulty swallowing?	Yes	No
Painful swallowing?	Yes	No
Indigestion or heartburn?	Yes	No
Gallbladder trouble or stones?	Yes	No
Nausea or vomiting?	Yes	No
Vomiting blood or coffee ground-like?	Yes	No
Yellow jaundice?	Yes	No
Hepatitis?	Yes	No
Constipation?	Yes	No
Diarrhea?	Yes	No
Abdominal pain or cramping?	Yes	No
Change in consistency or diameter of stool?	Yes	No
Hemorrhoids?	Yes	No
Any black or tarry stools?	Yes	No
Any blood in the stool?	Yes	No

GENITOURINARY:

Pain or burning with urination?	Yes	No
Blood in the urine?	Yes	No
Increased urinary frequency?	Yes	No
Kidney failure?	Yes	No
Trouble starting or stopping urine?	Yes	No
Getting up at night to urinate?	Yes	No
Incontinence?	Yes	No
Men: Prostate enlargement?	Yes	No
PSA elevation?	Yes	No

MUSCULOSKELETAL:

Bone pain?	Yes	No
Rheumatoid or osteoarthritis?	Yes	No
Osteoporosis?	Yes	No

NEUROLOGICAL:

Headaches – frequent or severe?	Yes	No
Dizziness or fainting?	Yes	No
Have you ever had a seizure?	Yes	No
Any numbness or tingling?	Yes	No
Difficulty walking?	Yes	No
Difficulty with speech/slurred?	Yes	No
Memory loss?	Yes	No

HEMATOLOGIC:

Bleeding problems?	Yes	No
Blood transfusion?	Yes	No
Easy bruising?	Yes	No
Excessive bleeding with surgery or dental work?	Yes	No
Have you had a blood clot?	Yes	No
Have you had a stroke?	Yes	No
Have you been on blood thinner?	Yes	No
Have you had a bone marrow biopsy?	Yes	No

INTEGUMENTARY:

Changes in skin, hair or nails?	Yes	No
Do you have a lot of itching?	Yes	No
Do you have a rash?	Yes	No

ENDOCRINE:

Enlarged thyroid or goiter?	Yes	No
High blood sugar?	Yes	No

FOR WOMEN ONLY:

Breast lump or mass?	Yes	No
Abnormal mammogram?	Yes	No
Last mammogram_____		
Abnormal Pap smears?	Yes	No
Age at first period _____		
Last menstrual period _____		
Age at first pregnancy _____		
Previous miscarriage?	Yes	No
Did you breastfeed?	Yes	No
Have you taken hormones?	Yes	No
Have you taken birth control pills?	Yes	No
Any hot flashes?	Yes	No
Heavy bleeding or clots with period?	Yes	No

Acknowledgement for Notice of Privacy Practices

HANNA CANCER ASSOCIATES

Patient Name:_____D.O.B._____SSN#_____

By signing below, I acknowledge that I have been given a copy of Hanna Cancer Associates Notice of Privacy Practices or one has been made available to me.

Patient Signature:_____ Date:_____

May we leave messages for you on your voicemail/answering machine? YES___ NO___

List any one that may call and get personal health information on your behalf:

1._____ Relationship:_____

2._____ Relationship:_____

3._____ Relationship:_____

[redacted]

MEDICAL RECORDS RELEASE FORM

I, hereby authorize this medical practice, Hanna Cancer Associates to release health information for patient named below:

Patient Name:_____ Date of Birth:_____Phone#:_____

Reason for Release:_____

Please SEND Information TO:
Please Print

_____	_____
Name of Provider/Clinic/Organization	Family Member & Relationship
_____	_____
Address	Address
Fax:_____	Fax:_____

I, AUTHORIZE the following information to be disclosed: (Please initial all that apply)

_____Entire Record

_____Records of care from the following dates:_____ to _____.

_____Other, please specify:_____

- **HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other Causative agent of AIDS with the rest of my medical records.**

Initial:_____**Date:**_____

Patient Signature:_____Date:_____