17333 S. La Grange Road
Tinley Park, IL 60487

Name:____Date:______________________

Home Address:____SSN#:______________________

City:____________________________________State:__________ZIP:______________________

Home Phone:____________________ Work Phone:________________ Cell :Phone:________________

Birthdate____________________ Marital Status:______________ Name of Spouse:______________

Email Address:____

Patient's Occupation:______________________ Patient Employer:__________________________

Patient's Primary Care Physician:____

Patient Allergies:) (drug, latex, environmental)_______________________________________

Emergency Contact:____________________________________Relationship:__________________

Emergency Contact Phone Number(s)____

The U.S. Government requests this information in connection with this practice's implementation of electronic health records. If you do not wish to provide this information, please indicate by writing "refused" and initial each question.

Language spoken _________________Race_______________ Ethnicity: □Hispanic OR □Non-Hispanic

Insurance Information:

***Primary Insurance**______________________ Name of Policy Holder______________________

Policy Number__________________________ Group Number:____________________________

Eligibility Telephone Number:______________ Patient's relationship to Policy Holder____________

Date of Birth:___________________ SSN#:_______________________Co Pay amount____________

***Secondary Insurance:**____________________ Name of Policy Holder:____________________

Policy Number: __________________________ Group Number____________________________

Eligibility Telephone Number:______________ Patient's relationship to Policy Holder:____________

Date of Birth:___________________ SSN#:_______________________ Co Pay amount____________

I have provided medical insurance information and copies of my insurance card(s). I authorize payment of medical benefits to Alpha Med Physicians Group, LLC. I authorize the release of any medical information necessary to process my claims.

X____

I authorize release of my medical tests and/or records to Alpha Med Physicians Group, LLC.

X____

Alpha Med Radiation Oncology

New Patient intake form

NAME: ______________________ **DATE:** ____________________

Age: _______ D.O.B._______________ Birthplace: City__________________ State: ___________________

County: __________________ Occupation: _________________________ Industry: _________________

Race: ____________________ Language: ___________________________

Referring Physician: ______________________ **Primary Physician:** _________________________

Surgeon: _________________________________

Preferred Pharmacy: ________________________ Address and Phone: ______________________

Prior surgeries and date? If so, list when and where:

____

____

Medications: ____

Allergies: ____

If female, # of pregnancies: ___________ **# of live births:** _______________

Any family history of cancer?

Relationship: _________________Maternal / Paternal Type of cancer: ___________________

Relationship: _________________Maternal/ Paternal Type of cancer: ___________________

Relationship: _________________Maternal / Paternal Type of cancer: ___________________

Do you have any of the following	**Yes**	**No**	**Any blood relative ever had?**	**Yes**	**No**	
Pneumonia			Diabetes			
Arthritis			Heart disease			
Heart disease			High blood pressure			
Pacemaker/ Defibrillator			Stoke			
Gall bladder disease			Epilepsy			
Anemia			Ulcer			
Bladder disease			Bladder disease			
Epilepsy						
			Have you ever smoked Cigarettes?	Yes, Currently	Yes Former	Never
Diabetes						
High blood pressure			Quit date			
Bowel disease			How many years			
Asthma			How many packs per day			
Other			Pipe, Cigar, Snuff, Chew?			
			Do you drink alcohol?			
			# of drinks per week			
			Beer, Wine, Liquor			

Is there any other medical history? ____

Are you currently in a nursing home? _________________

Review of Systems/Medical and Family History

Patient Name:______________________________________ Date:__________________________________

Name of Primary / Family physician:____

Please indicate below if you are experiencing any of these symptoms.

General, Constitutional	No	YES	**Musculoskeletal**	No	Yes
Good general health lately			Joint Pain		
Recent weight change			Joint stiffness or swelling		
Fever			Weakness of muscles/joints		
Fatigue			Muscle pain or cramps		
Fever, chills, night sweats			Back pain		
Eyes and Vision	No	Yes	Cold extremities		
Eye disease or injury			Difficulty walking		
Wear glasses or contact lenses			**Skin and Breasts**	No	Yes
Blurred or double vision			Rash or itching		
Glaucoma			Change in skin color		
Ears, Nose, Throat	No	Yes	Change in hair or nails		
Hearing loss			Varicose veins		
Ringing in ears			Breast pain		
Earaches or drainage			Breast lump		
Sinus problems			Breast discharge		
Nose bleeds			**Neurological**	No	Yes
Mouth sores			Frequent or recurrent headaches		
Bleeding gums			Light headed or dizziness		
Bad breath or bad taste			Convulsions or seizures		
Sore throat or voice change			Numbness or tingling sensations		
Swollen glands in neck			Tremors		
Heart or Cardiovascular	No	Yes	Paralysis		
Heart trouble			Stroke		
Hypertension			Head injury		
Chest pains			Balance difficulties		
Sudden heartbeat changes			Difficulty speaking		
Swelling of feet, ankles, hands			Loss of consciousness		
Palpitations, irregular heart beat			**Psychiatric**	No	Yes
Respiratory	No	Yes	Memory loss or confusion		
Frequent coughing			Nervousness		
Spitting up blood			Depression		
Shortness of breath			Sleep problems		
Asthma or wheezing			Anxiety		
Gastrointestinal	No	Yes	**Endocrine**	No	Yes
Loss of appetite			Glandular or hormone problems		
Change of bowel habits			Thyroid disease		
Nausea or vomiting			Diabetes		
Frequent diarrhea			Excessive thirst or urination		
Painful bowel movements			Heat or cold intolerance		
Constipation			Change in hat or glove size		
Blood in stool			**Hematologic/Lymphatic**	No	Yes
Stomach pain			Slow to heal after cuts		
Genitourinary	No	Yes	Easily bruise or bleed		
Frequent urination			Anemia		
Burning or painful urination			Phlebitis		
Blood in urine			Recent Transfusions		
Change in force of strain with urination			Swollen glands		
Incontinence or dribbling			Other		
Kidney Stones					
Sexual difficulty					
Painful periods					
Irregular periods					
Vaginal discharge					

Signature:____ Date:______________________