Susannah Friemel, M.D.
Linda Jager, M.D.
Tami Sheldon, A.R.N.P.

1750 E. 53rd Street
Davenport, IA 52807
563-345-HEAL(4325)
Fax: 563-345-4326

To help us learn more about you and your healthcare needs, please complete this form prior to visit.

PATIENT INFORMATION

Patient's Name Last:	First:	Middle:
Maiden Name:	Date of Birth:	Age:
Address:	Phone:	Email:
City, State & Zip:	What you like to be called:	
Social Security Number:(no dashes)	Gender: ☐ M ☐ F	Marital Status: (please check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Preferred Language: ☐ English ☐ Spanish ☐ Other:_____	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline	Race: (check all that apply) ☐ White ☐ Black/African American ☐ Asian ☐ American ☐ Indian ☐ Alaskan ☐ Other:_____
Primary Care Provider:	Preferred Pharmacy:	Preferred Pharmacy Location:
Emergency Contact:	Relationship to You:	Phone:
Employer:	Occupation:	

INSURANCE INFORMATION

Please provide a copy of all insurance cards to front desk. **If you bring your insurance card with you, you do not need to fill out this section.**

(Please check one) ☐ Medicare ☐ Public Aid ☐ United Health Care ☐ Wellmark/BCBS

☐ Other: _____

Policy #:	Group #:	
Policy holder:	DOB: / /	Phone:

Address:

_____

City, State & Zip:

_____

PATIENT HISTORY

Please list all ALLERGIES (food, drug, environmental) _____ No known allergies

_____ _____
_____ _____
_____ _____

Please list all medications you are currently taking, including over the counter and herbal supplements.
You can attach your medication list if available. _____ No medications

Medication	Dosage	Times/day

Tobacco use: ☐ Never ☐ Minimal ☐ Yes, currently ____packs/day for ____years
Previous use: Quit date_____ ____packs/day for ____years Other: (cigars, chew, etc.) _____
Are you interested in smoking cessation? ☐ Yes ☐ No

Iowa Cancer Specialists offers both individual and group smoking cessation classes. Are you interested in learning more about this opportunity? ☐ Yes ☐ No

Alcohol (please check one): ☐ Never ☐ Rarely ☐ Less than 10 /week ☐ More than 10 /week

Illicit drug use (please check one): ☐ No ☐ Yes What type? _____

I am concerned about my use of alcohol or drugs (please circle one): ☐ Yes ☐ No

Do you have any Implantable Devices? If so, please list them

Device _____ **Device ID**_____ **UDI** _____

Device _____ **Device ID**_____ **UDI**_____

What else would you like for us to know about you?

_____

_____

_____

PATIENT MEDICAL HISTORY

Please check all that pertain to *your personal history:*

☐ Anxiety ☐ Depression ☐ Seizures ☐ Headaches/Migraines ☐ Arthritis ☐ Osteoporosis

☐ Anemia ☐ Abnormal Bleeding/Blood disorder ☐ Stroke ☐ DVT ☐ Thyroid problems ☐ Irregular heat beat

☐ High blood pressure ☐ Heart disease ☐ Diabetes ☐ Asthma ☐ COPD ☐ Kidney disease ☐ Liver disease

☐ Cancer (please specify what type of cancer and approximate date of diagnosis)

_____

_____

_____

Past surgical history/major illness or hospitalization (please include approximate date)

_____

_____

_____

_____

Preventive care (please list approximate date of most recent procedure)

Colonoscopy _____ ☐ Normal/ ☐ Abnormal (check one)
Prostate exam _____ ☐ Normal/ ☐ Abnormal
Mammogram _____ ☐ Normal/ ☐ Abnormal
Pap test _____ ☐ Normal/ ☐ Abnormal

If you circled abnormal for any of the tests listed above, please provide information on where we may obtain results for our records.

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please check all that pertain to *your family members:*

☐ High blood pressure ☐ Heart disease ☐ Stroke ☐ Bleeding disorders ☐ Diabetes ☐ Osteoporosis

Cancer (type)	Family member	Age at diagnosis	Living?
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

(For office staff only- patient meets NCCN guidelines for genetic testing ☐ Yes ☐ No)

At Iowa Cancer Specialists, we value you as our patient and offer a variety of services to provide a holistic approach to your care.

Please let us know if you are interested in any of the following resources listed below.

Smoking cessation ☐

Individual lifestyle intervention/weight management ☐

Group Wellness classes ☐

Perimenopause/menopause symptoms ☐

Palliative care counseling ☐

We look forward to working with you to achieve your healthcare goals!

INSURANCE AND MEDICAL POLICY INFORMED CONSENT

I request that payment of authorized Medicare or other insurance company benefits be made on my behalf to Iowa Cancer Specialists, PC (ICS) for any services furnished to me by ICS. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim If I have additional insurance policies, my signature authorizes releasing information to the insurers or agency shown. In Medicare or other insurance company assigned cases, the doctor will accept the charge and determination of Medicare or other insurance as the full charge and the co-insurance and the deductible are based upon the charge determination of Medicare or other insurance company(s).

I also understand that my signature authorizes ICS to perform medical testing and/or treatment which may include, but are not limited to, blood tests, bone marrow, lumbar puncture, and/or chemotherapy, if necessary.

Signature: _____ Date: _____

Print name: _____