ROBERT A. MOSS, M.D., F.A.C.P., INC.

Hematology and Oncology

Board Certified in
Internal Medicine,
Medical Oncology,
and Hematology

11100 Warner Avenue
Suite #200
Fountain Valley, CA 92708
(714) 641-1128

To Our New Patient:

We welcome you to the practice of Robert A. Moss, M.D., F.A.C.P., Inc.

Initial consultations are typically one hour. If you are unable to keep your scheduled initial appointment, we require a 72 hour notice of cancellation. This affords the opportunity for our office to accommodate other new patients.

When you arrive, please check-in. Have your current insurance card, a government issued photo ID, and be prepared to pay your co-payment and/or deductible. You may be required to obtain pre-authorization from your insurance company or primary care physician before you can be seen. It is your responsibility to obtain this pre-authorization and bring it with you to your scheduled appointment.

In order for Dr. Moss to give you the most complete and thorough evaluation at your consultation, the following items will be necessary for his review:

- All relevant medical records from referring physician (ie. labs, x-rays, imaging reports, CD's of scans, pathology, and operation reports).
- Notes and reports may be faxed to our office at (714) 540-7610.

We hope the above information has been helpful. We look forward to meeting you.

Robert A. Moss, M.D.,F.A.C.P., INC.

Patient Information

Date_____ Patient Name_____ Home Phone#_____
Last First Middle
SSN_____ ☐ Male ☐ Female Birthdate_____ Cell Phone#_____
Address_____ City_____ State_____ Zip_____
E-mail Address_____
Marital Status (check appropriate box) ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Patient's Employer_____ Work Phone#_____

Spouse's Name_____ Cell Phone#_____ Work Phone#_____
Emergency Contact_____ Relationship:_____ Phone#_____
Referring Physican_____

Responsible Party (if different from patient)
Name_____ Relationship to Patient_____
Address_____ City_____ State_____ Zip_____
Drivers License#_____ Birthdate_____ Home Phone#_____
Employer_____ Work Phone#_____
Is this person currently a patient at our office? ☐ Yes ☐No

Insurance Information
Insurance Company_____
Ins. Co. Address_____ City_____ State_____ Zip_____
Name of Insured_____ Relationship to Patient_____ Birthdate_____
Insurance ID#_____ Group #_____
Employer_____ Work Phone#_____
Address of Employer_____ City_____ State_____ Zip_____
How much is your deductible? _____ How much have you used? _____ How much is your copay? _____

Do you have additional insurance? ☐Yes ☐No If yes, please complete the following:

Insurance Company_____
Ins. Co. Address_____ City_____ State_____ Zip_____
Name of Insured_____ Relationship to Patient_____ Birthdate_____
Insurance ID#_____ Group #_____
Employer_____ Work Phone#_____
Address of Employer_____ City_____ State_____ Zip_____
How much is your deductible? _____ How much have you used? _____ How much is your copay? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____
Signature of patient or parent if minor Date

Medical History Form
Robert A. Moss, M.D., F.A.C.P., Inc.

Briefly describe why you are here:

_____
_____
_____

Previous Surgeries and Dates:

_____
_____
_____

Medical Illnesses: (Please Circle)

Heart Disease?	Y or N
Lung Disease?	Y or N
Kidney Disease?	Y or N
Diabetes?	Y or N
High Blood Pressure?	Y or N
Other?	

Present Medications:

_____
_____
_____
_____

Allergies:

_____
_____

Personal History

Do you smoke?	Y or N
If yes, how much?	_____
Quit smoking how long ago?	_____
Illicit Drug Use?	Y or N
Do you drink alcohol? Y or N	Y or N
If yes, how much?	_____

What type of work do (did) you do?

_____

Are You Retired?	Y or N
Married?	Y or N
Children?	Y or N
If yes, how many?	_____
Are you sexually active?	Y or N

Family History

Mother:	**Alive or Dead**
Age:	
Cause of Death:	
Other Illnesses?	
Father:	**Alive or Dead**
Age:	
Cause of Death:	
Other Illnesses?	

Siblings (brothers or sisters)
Give Sex, Ages and Illnesses

_____
_____
_____

Family History of Cancer:

_____
_____
_____

Family History of Abnormal Bleeding or Blood Clots

_____
_____

Serious Illnesses in Offspring (Children)

_____

Systems Review

Do you presently have the following?

Headaches?	Y or N	Fevers?	Y or N
Double Vision?	Y or N	Sweats?	Y or N
Sore Throat?	Y or N	Unexplained Weight Loss?	Y or N
Difficulty Swallowing?	Y or N	Swollen glands or lumps?	Y or N
Cough?	Y or N	Skin Rashes?	Y or N
Chest Pain?	Y or N	Itching?	Y or N
Shortness of Breath?	Y or N	Easy Bruising?	Y or N
Nausea?	Y or N	Nosebleeds?	Y or N
Vomiting?	Y or N	Other Abnormal Bleeding?	Y or N
Diarrhea?	Y or N	Arthritis?	Y or N
Constipation?	Y or N	Bone Pain?	Y or N
Abdominal Pain?	Y or N	Other Pains?	Y or N
Blood in the Stool?	Y or N	Seizures?	Y or N
Urination Pain or Burning?	Y or N	Loss of Consciousness?	Y or N
Bloody Urine?	Y or N	Weakness of one part of the body?	Y or N
Vaginal Bleeding?	Y or N	Dizziness of lightheadedness?	Y or N

Name (Please Print)_____

Signed _____ Date_____