CHARLESTON CANCER CENTER
Dedicated to Your Tomorrow

WELCOME TO OUR OFFICE. IN ORDER TO SERVE YOU PROPERLY, WE WILL NEED THE FOLLOWING INFORMATION FILLED OUT COMPLETELY AND UPDATED AS NECESSARY.

PATIENT INFORMATION

LAST NAME: ____________________________________ FIRST NAME:___________________________ MI: _____

DO YOU CURRENTLY LIVE IN A NURSING HOME OR ASSISTED LIVING FACILITY OR A SKILLED NURSING UNIT? _____________
ARE YOU CURRENTLY ENROLLED IN HOSPICE CARE? ________
IF YES, EFFECTIVE DATE AND NAME OF HOSPICE? ______________

HOME ADDRESS:_______________________________________ CITY/STATE/ZIP: ______________________________

HOME PHONE: ___________________________ CELL PHONE: ___________________________________

DATE OF BIRTH: ____/____/____ AGE: ____ SEX: ____ SOCIAL SECURITY # ______-_______-________

EMAIL: ____

MARITAL STATUS: MARRIED__ DIVORCED__SINGLE__OTHER__

DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)? YES ______ NO ________
IF YES, PLEASE PROVIDE A COPY.

ETHNICITY: HISPANIC OR LATINO___ NOT HISPANIC OR LATINO ____
RACE: AMERICAN INDIAN OR ALASKA NATIVE _____, ASIAN_____, BLACK OR AFRICAN AMERICAN_____, HISPANIC OR LATINO_____, WHITE_____, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER_____, OTHER RACE_____

EMERGENCY CONTACT

PLEASE MAKE SURE YOUR EMERGENCY CONTACT IS ON YOUR HIPAA FORM.

EMERGENCY CONTACT NAME: ________________________________ RELATIONSHIP: ___________________________

PHONE: ______________________________ CELL PHONE: _________________________________

PHYSICIAN AND PHARMACY

LOCAL PHARMACY: _______________________________________ PHONE NUMBER: ____________________________

FAMILY PHYSICIAN:_______________________________________ REFERRING PHYSICIAN:______________________

INSURANCE INFORMATION

PRIMARY INSURANCE:________________________________ POLICY NUMBER: _________________________________
POLICY HOLDER'S NAME: _____________________________ RELATIONSHIP: __________________________________
POLICY HOLDER'S SOCIAL: _____/_____/_______ POLICY HOLDER'S DOB: ______/______/______

SECONDARY INSURANCE: ____________________________ POLICY NUMBER: _________________________________
POLICY HOLDER'S NAME: ____________________________ RELATIONSHIP: __________________________________
POLICY HOLDER'S SOCIAL: ______/______/______ POLICY HOLDER'S DOB: ______/______/______

YOUR SIGNATURE INDICATES THAT YOU CONSENT TO: 1. AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CHARLESTON CANCER CENTER. 2. AUTHORIZE RELEASE OF INFORMATION TO YOUR INSURANCE COMPANY. 3. PERSONAL RESPONSIBILITY FOR ALL SERVICES RENDERED TO YOU. 4. AUTHORIZE YOUR PHYSICIAN TO PROVIDE MEDICAL TREATMENT.
I BELIEVE THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.
PATIENTS SIGNATURE:_______________________________ DATE__________________________________