

**Cancer Center**  
**Patient Questionnaire**

Billing Use Only

DX \_\_\_\_\_  
FC \_\_\_\_\_  
REF \_\_\_\_\_  
UPIN \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_  
(Street or Box No.) (City) (State) (Zip) (County)

Home Phone No.: \_\_\_\_\_ Work Phone No.: \_\_\_\_\_

Cellular Phone No.: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Sex: Male  Female  Age: \_\_\_\_\_ Diabetic: Yes  No

Please list any allergies: \_\_\_\_\_

Race: Caucasian  African American  Hispanic  Asian  Native American  Other

Marital Status: Single  Married  Divorced  Widowed

Employment Status: Full-Time  Part-Time  Does Not Work  Retired – Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street or Box No.) (City) (State) (Zip)

Spouse's Name: \_\_\_\_\_

Spouse's Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Employer's Phone No.: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street or Box No.) (City) (State) (Zip)

“My medical information can be discussed with \_\_\_\_\_  
(Name of person or persons)

EMERGENCY CONTACT: \_\_\_\_\_ NUMBER: \_\_\_\_\_

Nearest Relative Not Residing at Your Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ Work Phone No.: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

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Comments: \_\_\_\_\_

\_\_\_\_\_

I authorize my physician to bill my insurance company(ies) for charges incurred during the course of my treatment and to provide any medical information necessary to process this claim. I authorize payment to be made directly to my physician, to inquire about my accounts, and to receive any information about any and all my Medicare, Blue Shield or other insurance claims assigned or non-assigned and I understand that I am fully responsible for charges incurred with this treatment even though the doctor files my insurance for me. I understand that delinquent accounts are subject to collection and acknowledge responsibility.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date