Cancer Center
Patient Questionnaire

Billing Use Only
DX________________________
FC________________________
REF_______________________
UPIN______________________

Diagnosis:____ Date of Diagnosis: ______________________

Please list any allergies: ____

Name:____
(First) (Middle) (Last)

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

Primary Phone #: ____________________ ☐ Cell ☐ Home ☐ Work Okay to leave message? Yes ☐ No ☐

Alternate Phone #: __________________ ☐ Cell ☐ Home ☐ Work Personal Email:_____________________

Date of Birth:___________________ Age:____________ SSN:__________________________

Sex: Male ☐ Female ☐ Diabetic: Yes ☐ No ☐ Primary Language: __________________

Race: Caucasian ☐ AA/Black ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Other ____________ ☐

Marital Status : Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employment Status: Full-Time ☐ Part-Time ☐ Does Not Work ☐ Retired – Date:__________

Occupation (even if retired):_________________________ 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 #:___________________________

Employer’s Address:____
(Street or Box No.) (City) (State) (Zip)

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

____”

EMERGENCY CONTACT: ______________________________ PHONE #: __________________

Nearest Relative Not Residing at Your Address:____

Relationship to Patient:________________________________

Primary Phone #: ____________________ ☐ Cell ☐ Home ☐ Work Okay to leave message? Yes ☐ No ☐

Pharmacy Name:______________________________ Phone No.:________________________________

Referring Physician:____

Address:____
(Street) (City) (State) (Zip)

Cancer Center

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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

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The Cancer Center works collaboratively with the American Cancer Society (ACS) to provide our patients accurate and timely information regarding their diagnosis, treatment options, community resources, support groups, coping, survivorship, etc. The American Cancer Society has agreed to mail you relevant information based on your diagnosis and preference. This information includes:

- A letter from the American Cancer Society
- Site specific cancer information
- Cancer Survivor's Network: Web-based support services for cancer survivors and their friends/family
- Talking with Your Doctor: Assists patients in building good relationships with health care providers
- After Diagnosis booklet: General information after a diagnosis, including common questions & answers
- General brochure for patient services and programs

If you would like to have this information sent to you please read the statement of understanding below and sign accordingly.

I understand the HIPAA (privacy) policy and agree with the disclosure of this information to the American Cancer Society (ACS) for the purposes of providing applicable information specific to my diagnosis. In addition, I agree that the American Cancer Society can provide information on upcoming patient programs and services available in my area. ACS is a private organization and does not share personal health information.

____ ____________________

Authorized Signature Date