MONTGOMERY CANCER CENTER

PATIENT INFORMATION SHEET

PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S NAME (LAST) (FIRST) (MIDDLE)		HOME TELEPHONE	PRIMARY CARE PHYSICIAN
ADDRESS	CITY	STATE	ZIP CODE
PLACE OF EMPLOYMENT	OCCUPATION	HOW LONG EMPLOYED?	WORK TELEPHONE

SEX	RACE	MARITAL STATUS S M D W	BIRTH DATE	RETIRED? Y N	SOCIAL SECURITY NUMBER
SPOUSE'S NAME			BIRTH DATE	RETIRED? Y N	SOCIAL SECURITY NUMBER

SPOUSE'S ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
SPOUSE'S PLACE OF EMPLOYMENT	OCCUPATION	TELEPHONE	
NEXT OF KIN (OTHER THAN SPOUSE)	HOME TELEPHONE	WORK TELEPHONE	
ADDRESS	CITY	STATE	ZIP CODE
PERSON TO NOTIFY IN CASE OF EMERGENCY	HOME TELEPHONE	WORK TELEPHONE	
HAVE YOU BEEN TREATED BY OUR DOCTORS BEFORE? IF YES, WHEN?	NAME OF PHARMACY TELEPHONE	REFERRING PHYSICIAN	

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT)

NAME (LAST) (FIRST) (MIDDLE)		TELEPHONE	
ADDRESS	CITY	STATE	ZIP CODE
RELATIONSHIP TO PATIENT	HOME TELEPHONE	WORK TELEPHONE	

INSURANCE INFORMATION

INSURANCE COMPANY (PRIMARY)	CONTRACT NUMBER	GROUP NUMBER		RELATIONSHIP TO POLICY HOLDER
ADDRESS	CITY	STATE	ZIP CODE	EFFECTIVE DATE
INSURANCE COMPANY(SECONDARY)	CONTRACT NUMBER	GROUP NUMBER		RELATIONSHIP TO POLICY HOLDER
ADDRESS	CITY	STATE	ZIP CODE	EFFECTIVE DATE
INSURANCE COMPANY(TERTIARY)	CONTRACT NUMBER	GROUP NUMBER		RELATIONSHIP TO POLICY HOLDER
ADDRESS	CITY	STATE	ZIP CODE	EFFECTIVE DATE

CANCER INSURANCE / ALTERNATIVE HEALTH PLAN

INSURANCE COMPANY	CONTRACT NUMBER	GROUP NUMBER		RELATIONSHIP TO POLICY HOLDER
ADDRESS	CITY	STATE	ZIP CODE	EFFECTIVE DATE

I/WE THE UNDERSIGNED GIVE PRIOR EXPRESSED CONSENT TO MONTGOMERY CANCER CENTER AND ITS EMPLOYEES AND/OR AGENTS, TO CONTACT ME AT ANY PHONE NUMBER(S), INCLUDING CELL PHONE NUMBER(S), FOR THE PURPOSE OF TREATMENT, INSURANCE BILLING, OR PAYMENT OF ACCOUNT.

PATIENT OR RESPONSIBLE PARTY SIGNATURE

DATE

Montgomery Cancer Center

PATIENT HISTORY FORM

DEMOGRAPHICS

Today's Date: ___/___/___ Patient's Name: _____
First MI Last

Date of Birth: ___/___/___ Sex: ❑ Male ❑ Female Race: ❑ African American ❑ Caucasian ❑ Asian ❑ American Indian/Aleut ❑ Pacific Islander ❑ Latin ❑ Other

SS#: _____–_____–_____

Referring Doctor: _____

Other Doctors: _____

Reason for your visit: _____

PMH

Illnesses / Diseases – check all that apply to you

❑ Heart Attack ❑ Hypertension ❑ Heart Disease ❑ Unusual Bleeding ❑ Blood Disorders ❑ Blood Clots
❑ Stroke ❑ Kidney Stones ❑ Diabetes ❑ Emphysema ❑ Cancer (describe below) ❑ Other (describe below)

_____

_____

SURGICAL/TREATMENTHISTORY

Previous surgery	Date of surgery	Surgeon's name

Please list any injuries:

Have you had …

Prior Radiation? ❑ No ❑ Yes Area: _____ # of Treatments: _____ Year: _____

Prior Chemotherapy? ❑ No ❑ Yes Type: _____ Year: _____

FAMILY HISTORY

Check all that apply	Father	Mother	Brother	Sister
Heart Attack	❒	❒	❒	❒
Hypertension	❒	❒	❒	❒
Heart Disease	❒	❒	❒	❒
Stroke	❒	❒	❒	❒
Blood Clots	❒	❒	❒	❒
Blood Disorders	❒	❒	❒	❒
Unusual Bleeding	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒
Cancer (describe)	❒	❒	❒	❒
Other (describe)	❒	❒	❒	❒

SOCIAL HISTORY

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Primary Caregiver: _____

Children: ❑ No ❑ Yes - # of children: _____ Education: Highest grade/degree completed: _____

Occupation: _____ Retired? ❑ No ❑ Yes
If retired list previous occupation

Any exposure to hazardous materials? ❑ No ❑ Yes Type: _____

SOCIAL HISTORY (cont)

Alcohol use at present? ❑ No ❑ Yes If yes, how much? _____ How often: _____

In the past? ❑ No ❑ Yes If yes, when did you quit? _____(date)

Tobacco use at present? ❑ No ❑ Yes Type: ❑ Cigarettes ❑ Cigars ❑ Oral Tobacco Daily amount: _____ # of years _____

In the past? ❑ No ❑ Yes If yes, when did you quit? _____(date)

Any illicit / recreational / street drug use / abuse? ❑ No ❑ Yes

If yes, please describe: _____

ALLERGIES

Drug or situation	(Please list the type of adverse reaction)

MEDICATIONS

Drug name	Dosage	How often

REVIEW OF SYSTEMS

Check all that apply:

❑ Weight Loss
❑ Fever
❑ Night Sweats
❑ Generalized weakness
❑ Loss of Appetite
❑ Double Vision
❑ Blurred Vision
❑ Ear Pain
❑ Throat Pain
❑ Hoarseness
❑ Trouble swallowing

❑ Shortness of Breath
❑ Coughing up blood
❑ Wheezing
❑ Cough: ❑ Wet ❑ Dry
❑ Chest pain
❑ Leg swelling
❑ Heart too fast / slow
❑ Nausea
❑ Vomiting
❑ Diarrhea
❑ Constipation
❑ Passing blood

❑ Headaches
❑ Fainting
❑ Dizziness
❑ Localized weakness / numbness
❑ Pain (where/describe)
_____
Last CXR (date) _____
❑ Other bleeding (where/describe)
_____
_____

❑ Pain in bones
❑ Pain in joints
❑ Depression
❑ Anxiety

Last Rectal Exam (date) _____
Last Colonoscopy/Flex Sig (date) _____
❑ Skin rashes/change in a mole (where/describe): _____
_____

FEMALES ONLY

Menstrual Cycle: ❑ Regular ❑ Irregular ❑ Heavy ❑ Light ❑ Passing clots
❑ Spotting between cycles ❑ Cramps

Date last menstrual cycle: ___/___/___ Menopause? ❑ No ❑ Yes If yes, date: ___/___/___

Date last pap smear: ___/___/___ Date last breast exam: ___/___/___ Bra size: _____ (Breast cancer patients only)

Date last mammogram: ___/___/___ Location: _____

Financial Policy

It is the policy of ***Montgomery Cancer Center*** that all fees including co-pays, deductibles and non-covered services are *due and payable on the date of service unless other payment arrangements have been made in advance*.

Insurance coverage is considered by ***Montgomery Cancer Center*** as an agreement between the patient, the insurance company and the employer, where applicable. ***Montgomery Cancer Center*** is not a party to that agreement and as a result is not bound by any of the covenants, limitations, or restrictions of that policy.

As a *service to our patients*, we will file insurance claims for the services provided. Itemized bills will be provided to you for those services upon request. The filing of insurance does ***NOT*** release the patient from responsibility for charges for services which have been provided.

Charges for services ***not covered by insurance*** are due when a patient statement is received unless specific arrangements have been made for an extension of time. If you have special needs, contact our Financial Counselor or Patient Account Representative for assistance. ***You are responsible*** for payment of services not paid in whole or in part by your insurance.

Statements showing the status of your account are mailed monthly. ***Montgomery Cancer Center*** is prepared to counsel any patient experiencing difficulty in meeting payment obligations. If you are unable to make payment when due, please contact our office as soon as you receive our statement.

Montgomery Cancer Center will use the services of an outside collection company in the collection of all debt accounts which are not paid within 90 days and for which no special arrangements have been made. You will be responsible for any fee(s) charged in collection of the lawful debt to include; collection fee(s), attorney fees, and/or court costs, if such is necessary.

Having read and understood ***Montgomery Cancer Center's Financial Policy***, I agree to the terms set forth.

_____ _____

Patient Date

_____ _____

Witness Date