**CANCER SPECIALISTS OF TIDEWATER, LTD.**
**PRACTICE LIMITED TO BLOOD DISORDERS AND CANCER MEDICINE**

Welcome to our practice. So that our staff can provide the best care and attention to your needs, we would appreciate your cooperation in completing the following:

"**PLEASE PRINT LEGIBLY**" Date: ________________________________________

**PATIENT NAME**:___________________________________________________________ SEX: F _____ M _____
LAST FIRST MIDDLE

**SSN**: ______________________ **DATE OF BIRTH**: ________________ **HOME PHONE**:___________________

**CELL PHONE#**__________________________ **EMAIL ADDRESS**:____________________________________

**CAN WE USE YOUR EMAIL TO CONTACT YOU**? YES____ NO____

**RACE**: Unknown____ African American____ Asian____ Caucasian____ Chinese____ Filipino____ Hispanic____ Japanese____ Native American____ Native Hawaiian____ Pacific Islander____ Other____

**LANGUAGE SPOKEN**____________________________________

**HOME ADDRESS** __________________________________________________________ APT. #_____________

CITY: __________________________________________ STATE: ______________________ ZIP: ____________

**EMPLOYER**: __________________________________________________WORK PHONE:__________________

**SPOUSE**: ____________________ **SPOUSE'S EMPLOYER**: ___________________________________________

PLEASE LIST THE NAMES OF ALL RELATIVES, FRIENDS AND CAREGIVERS YOU WILL ALLOW US TO SHARE YOUR PROTECTED HEALTH INFORMATION WITH:

_______________________________________________ _______________________________________________

_______________________________________________ _______________________________________________

_______________________________________________ _______________________________________________

**PERSON TO CONTACT IN CASE OF EMERGENCY**: (Name, Relationship and Phone Number)
_____________________________________________________________________________________________

NAME OF PERSON WHO REFERRED YOU TO US: ________________________________________________
(Physician, Relative, Friend, Phone Book or Other)

NAME OF FAMILY PHYSICIAN: __________________________________________PHONE #:______________

OTHER PHYSICIANS WHO CARE FOR YOU: _________________________________________________________

**Do you have a Living Will? ___ Yes ___ No**

**Do you have a Medical Power of Attorney? ___ Yes ___ No**

**If yes, may we please have a copy for your medical record?**
**If no, would you like some information?**

ACKNOWLEDGEMENT FOR AIDS TESTING: I understand the possibility exists that as a result of my treatment healthcare workers may be directly exposed to my blood or body fluids. In the event of such a direct exposure in a manner which may, according to the Center for Disease Control guidelines, transmit AIDS (Acquired Immune Deficiency Syndrome), a sample of my blood will be tested for the presence of infectious diseases, such as hepatitis, syphilis, and AIDS. I further understand that the results of the tests will be released to me and to any healthcare worker who suffered an exposure.

DATE: __________________________ PATIENT'S SIGNATURE: _____________________________________

**PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST**

1. PRIMARY INSURANCE ____________________________________________________________________

   SUBSCRIBER NAME ____________________________________________________________________

   SUBSCRIBERS SOCIAL SECURITY NO: ________________________DOB:___________________________

2. SECONDARY INSURANCE ____________________________________________________________________

   SUBSCRIBER NAME ____________________________________________________________________

   SUBSCRIBERS SOCIAL SECURITY NO: _______________________ DOB:___________________________

I authorize Cancer Specialists of Tidewater, Ltd., to file my insurance for all services rendered. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible for payment of any charges or services provided which are not covered or paid by my insurance.

In the event my account becomes delinquent and is turned over to an attorney or collection agency for collection, I agree to pay attorney's and collection agency fees of 35 percent (35%) of the unpaid portion at the time of referral.

Patient Signature: ____________________________________________________________________

Social Security Number: ____________________________________________________________________

Date: ____________________________________________________________________

I hereby guarantee payment of any costs associated with the treatment and services provided by Cancer Specialists of Tidewater, Ltd., to the herein named patient, or on his or her behalf, in accordance with the same terms and conditions as set forth above.

Signature of spouse or
Other responsible person: ____________________________________________________________________

Social Security Number: ____________________________________________________________________

Address: ____________________________________________________________________

Phone Number: ____________________________________________________________________

Date: ____________________________________________________________________