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**: _____

SPOUSE'S PHONE NUMBER_____

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.

Patient Signature: _____

Social Security Number: _____

Date: _____