NEW PATIENT FORM

Today's Date:_____

(Please print. Thank you.)

Patient Name:_____MRN#: _____

DOB:_____/_____/_____Age_____Male Female SSN: _____

Address:_____ Phone: (_____) _____

Cell Phone: (_____) _____

City:_____State:_____Zip:_____

Secondary Address: _____

City:_____State:_____Zip:_____

May we leave a message on your answering machine / voicemail? ____Yes ____No

Email Address:_____May we email you? ____Yes ____ No

Preferred Language: _____

Ethnicity/Race: ___White_____Hispanic/Latino_____Black/African American_____Native American_____Asian/Pacific Islander ___Other

Primary Care Physician: _____ Phone: _____

Referring Physician (if different): _____ Phone: _____

Other Physician _____ Phone: _____

Other Physician _____ Phone: _____

Other Physician _____ Phone: _____

Other Physician _____ Phone: _____

Emergency Contact Name: _____

Relationship: _____ Phone: (____) _____

Power of Attorney (if applicable): _____ Relation to you: _____

Living Will: _____ Yes* _____ No *Please provide a copy for your records

DNR: _____ Yes* _____ No *Please provide a copy for your records

NEW PATIENT FORM

Patient Name: _____

Primary Insurance Carrier

Name of primary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier

Name of secondary policy holder: _____

Policy holder's Date of Birth: _____ Policy holder's SS#: _____

Policy holder's employer: _____

Policy holder's employer address: _____

Policy holder's employer phone #: _____

Does plan have prescription coverage? ☐ Yes ☐ No

Where did you learn about RCCA?

☐ Physician Referral ☐ Family / Friends ☐ Insurer

☐ Advertisement ☐ Internet Search ☐ RCCA Website

I certify that the information I have given today is to the best of my ability and as fully and accurately as possible. I will notify the doctor/staff to any changes or additions at subsequent visits.

Signature: _____ Date: _____

Print Name: _____

REQUEST FOR RELEASE OF RECORDS

I,_____, request a copy of my complete medical record from the office of:

_____

Name and Address of Practitioner

_____

To be sent to Regional Cancer Care Associates:

_____

Address, City State Zip Code

_____

Fax/Telephone Number

_____I give permission to Fax my medical records to the above listed person, company or medical facility. I understand that my records will be sent via telephone communication.

_____

Provide office fax number

It is my understanding that by signing this authorization for release of my records, I am giving permission for Regional Cancer Care Associates to receive copies of any medical, psychiatric, AIDS, Aids Related syndromes, HIV Testing, Alcohol and/or drug abuse related information for the above listed person(s) or organization. I also understand that this authorization may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire 1 year after the date below or sooner at my election.

_____ _____

Print Patient Name Date

_____ _____

Signature Patient, Parent, or Legal Guardian/Representative Date

_____ _____

Witness Date

Regional Cancer Care Associates LLC ("RCCA") is committed to protecting the privacy of individual health information in compliance with the Health Insurance Portability and Accountability Act and Health Information Technology for Economic and Clinical Health Act (both Acts together, "HIPAA") and the regulations promulgated there under. These policies and procedures apply to protected health information ("PHI") created, received, maintained or transmitted by RCCA after April 13, 2013.