RCCA
REGIONAL CANCER CARE ASSOCIATES LLC

NEW PATIENT FORM

Today's Date:_____

(Please print. Thank you.)

Patient Name:_____

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_____

PHYSICIAN	NAME	ADDRESS	PHONE
Primary Care Physician			
Referring Physician (if different)			
Other Physician			
Other Physician			
Other Physician			
Other Physician			

Emergency Contact Name:_____

Relationship:_____ Phone: (_____) _____

Durable Medical Power of Attorney (if applicable):_____Yes* _____No *Please provide a copy for your records.

Relationship to you:_____

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

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

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NEW PATIENT FORM

Patient Name: _____DOB:_____/_____/_____

Primary Insurance Carrier

Name of primary policyholder:_____

Name of insurance company:_____ Policy Number:_____

Policyholder's Date of Birth:_____ Policyholder's SS#:_____

Policyholder's employer:_____

Policyholder's employer address:_____

Policyholder's employer phone #:_____

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier

Name of secondary policyholder:_____

Name of insurance company:_____ Policy Number:_____

Policyholder's Date of Birth:_____ Policyholder's SS#:_____

Policyholder's employer: _____

Policyholder's employer address:_____

Policyholder'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 as fully and as accurately as possible. I will notify the doctor/staff of any changes or additions at subsequent visits.

Signature: _____Date: _____

Print Name: _____