CBCC
Comprehensive Blood & Cancer Center

PATIENT INFORMATION FORM

Date _____

Name _____
Male ____ Female____
Marital Status _____
Address _____
City_____State___Zip_____
Home Telephone # _____ Cell#_____
Email Address _____
(If minor, responsible party's e-mail)
Date of Birth_____ Age _____
Social Security # _____
Employer _____
Work Telephone # _____
Occupation: _____
If Student, Name of School: _____
_____
Language Spoken: _____
Race: □ White □ Black □ Hispanic
□ Decline to Answer □ Other _____
Ethnicity: □ Hispanic □ Non-Hispanic
□ Declined to Answer

Spouse or Responsible Party

Name _____
Address _____
City_____ State___ Zip_____
Home Telephone #_____ Cell# _____
Social Security # _____
Date of Birth _____ Age _____
Employer _____
Work Telephone # _____

Person to Contact in Case of Emergency:
Permission to discuss my treatment, diagnostic tests, and medical condition: ☐ Yes ☐ No
Name _____
Address _____
City _____ State ___ Zip _____
Telephone # _____
Relationship to Patient _____

Please bring your insurance card(s) with you and prescription card with you and present them to the Receptionist when you arrive for your appointment.

PRESCRIPTION DRUGS: To better meet our patients' needs we can dispense some of the prescriptions as prescribed by our physician(s). We will bill your pharmacy insurance and charge the applicable co-pay. Pease understand that you are not obligated to have prescriptions filled here and you have the option of receiving your medications from the pharmacy of your choice. We would be happy to facilitate this for you.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322 or www.mbc.ca.gov.

_____
Patient's Name Patient's Signature Date Signed

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