

INFORMATION NEEDED FOR CASE HISTORY FILE

Male Female

Patient's Last Name _____ First _____ MI _____ Today's Date _____

Birthdate _____ Age _____ City/State of Birth _____

Permanent Address _____ Home Phone (_____) _____

City, State, ZIP _____ Cell Phone (_____) _____

Temporary Address _____ Phone (_____) _____

City, State, ZIP _____

RACE (The State of California Tumor Registry asks cancer treatment centers to report patient race. You may decline to give this information if you choose.)

White Black Hispanic Native American Japanese Korean Chinese Filipino

Vietnamese Hawaiian Asian Indian, Pakistani Other: _____ Decline to state

Patient's Employer _____ Phone (_____) _____

Spouse/Next of Kin _____ Relationship _____

Home Phone (_____) Work Phone (_____) Cell Phone (_____)

Emergency Contact (not living with you) _____ Relationship _____

Home Phone (_____) Work Phone (_____) Cell Phone (_____)

Referring Physician _____ Phone (_____) _____

Address _____

Primary Care Physician _____ Phone (_____) _____

Address _____

Preferred Pharmacy _____ Phone (_____) _____

Address _____

MEDICAL INSURANCE COVERAGE - PLEASE BRING YOUR INSURANCE CARD

Primary Insurance Company _____

ID# _____ Group # _____

Subscriber's Name _____ Subscriber's DOB _____ Male Female

Secondary Insurance _____

ID# _____ Group # _____

Subscriber's Name _____ Subscriber's DOB _____ Male Female

RESPONSIBLE PARTY FOR PATIENT UNDER 18 YEARS OF AGE

Name _____ Relationship _____ Birthdate _____ Age _____

Address _____ City, State, Zip _____

Home Phone (_____) Cell Phone (_____)

Employer _____ Employer Phone (_____)

STAFF USE ONLY: ID VERIFICATION: ___ Photo ID ___ Other: _____ (Initials: _____)

I, _____
Print Patient Name

- Authorize my referring physician to release all medical information necessary to complete my medical care.
- Authorize RAS Sacramento Clinic for Hematology and Medical Oncology to request/obtain medical information/x-rays from other healthcare providers for the purpose of diagnosis and/or treatment.
- Authorize RAS Sacramento Clinic for Hematology and Medical Oncology to release any medical information/x-rays requested by other healthcare providers.
- Authorize the release of all medical information necessary to process this claim.
- Authorize payment of medical benefits directly to the physician or supplier of services itemized on said claim.
- Understand that fees are subject to change based on actual exam(s) performed.
- Understand that I am responsible for any charges or charge balances not paid by my insurance and agree to pay these amounts.
- Understand that in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay for reasonable attorney fees or other such costs as the court determines proper.
- I hereby acknowledge the receipt of a copy of the RAS Notice of Privacy Practices.

Initials

Date

X

Patient/Responsible Party Signature

Note: Declining to sign or altering this form will result in RAS being unable to provide service to you.