Appointment Date: _____
PSR Initials: _____

Updated July 24, 2018 tj

PATIENT INFORMATION SHEET

Georgia Cancer Specialists affiliated with Northside Hospital Cancer Institute

GCS Office Location: _____ Date_____ New Patient_____Insurance Change_____

GCS Physician: _____ Diagnosis: _____

Referring Physician: _____
First Name Last Name Phone Number

Primary Care Physican: _____
First Name Last Name Phone Number

PATIENT'S INFORMATION (PLEASE PRINT CLEARLY)

PATIENT'S NAME (LAST) (FIRST) (MI)		SOCIAL SECURITY NO. (last 4 digits) XXX-XX-	DATE OF BIRTH	SEX ☐ MALE ☐ FEMALE
PATIENT'S HOME ADDRESS			CITY / STATE	ZIP
HOME PHONE NUMBER	CELL PHONE NUMBER	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ LIFE PARTNER ☐ WIDOWED ☐ DIVORCED	EMAIL ADDRESS	
PATIENT'S EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ NOT EMPLOYED ☐ UNKNOWN ☐ RETIRED ☐ ACTIVE MILITARY ☐ SELF EMPLOYED		PATIENT'S WORK NUMBER	OCCUPATION	RETIREMENT DATE
EMPLOYER'S NAME & ADDRESS		ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO	RACE ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ WHITE ☐ OTHER ☐ UNKNOWN/NOT REPORTED	
PREFERRED LANGUAGE		INTERPRETER NEEDED ☐ YES ☐ NO	IS IT ALRIGHT FOR US TO LEAVE A MESSAGE ON: ☐ HOME ☐ CELL ☐ WORK	

INSURANCE INFORMATION

NAME OF FIRST INSURANCE / PHONE NUMBER		NAME OF SECOND INSURANCE / PHONE NUMBER	
NAME OF INSURED PERSON	RELATIONSHIP TO PATIENT ☐ Self ☐ Life Partner ☐ Spouse ☐ Other_____	NAME OF INSURED PERSON	RELATIONSHIP TO PATIENT ☐ Self ☐ Life Partner ☐ Spouse ☐ Other_____
INSURED PERSON'S SS#(Last 4 digits) XXX-XX	INSURED DATE OF BIRTH	INSURED PERSON'S SS # (Last 4 digits) XXX-XX	INSURED DATE OF BIRTH
EMPLOYER NAME		EMPLOYER NAME	
GROUP NAME	GROUP NUMBER	GROUP NAME	GROUP NUMBER
POLICY, CERTIFICATE OR ID NUMBER	PHONE NUMBER	POLICY, CERTIFICATE OR ID NUMBER	PHONE NUMBER

NAME OF THIRD INSURANCE/ PHONE NUMBER	
NAME OF INSURED PERSON	RELATIONSHIP TO PATIENT ☐ Self ☐ Life Partner ☐ Spouse ☐ Other_____
INSURED PERSON'S SS #(Last 4 digits) XXX-XX-	INSURED DATE OF BIRTH
EMPLOYER NAME	
GROUP NAME	GROUP NUMBER
POLICY, CERTIFICATE OR ID NUMBER	PHONE NUMBER

PATIENT'S NAME (LAST) (FIRST) (MI)	DOB

OTHER RESPONSIBLE PARTY'S OR SPOUSE'S OR SIGNIFICANT OTHER'S INFORMATION

NAME (LAST) (FIRST) (MI)	SOCIAL SECURITY NO. (Last 4 digits) XXX-XX-	DATE OF BIRTH	RELATION TO PATIENT

HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE NUMBER

EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ OTHER _____ ☐ RETIRED ☐ ACTIVE MILITARY	PHONE NUMBER	OCCUPATION	RETIREMENT DATE

EMPLOYER'S NAME & ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACT PERSON'S INFORMATION

NAME (LAST) (FIRST) (MI)	ADDRESS

HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER

RELATIONSHIP TO PATIENT	DOB	EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ NOT EMPLOYED ☐ UNKNOWN ☐ RETIRED ☐ ACTIVE MILITARY ☐SELF EMPLOYED	RETIREMENT DATE

The oncology clinic may need to contact you with important medical information. This may include critical lab results that require immediate medical attention to protect your health. We will always attempt to contact you first. In case you are unavailable, we are requesting contact information for at least one responsible adult who will be able to contact you at all times and can check on you in your home if necessary. Your emergency contacts will not be contacted for non-emergencies

OTHER CONTACT INFORMATION

NAME (LAST) (FIRST) (MI)	ADDRESS

HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER

RELATIONSHIP TO PATIENT	DOB	EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ NOT EMPLOYED ☐ UNKNOWN ☐ RETIRED ☐ ACTIVE MILITARY ☐SELF EMPLOYED	RETIREMENT DATE

Do you have a medical alert system to summon help in a medical emergency? _____ Yes _____ No
If yes, _____ Home base only _____Mobile
Name of company _____ Phone _____

Who is Georgia Cancer Specialists affiliated with Northside Hospital Cancer Institute allowed to discuss your medical care and billing/insurance?

NAME		NAME	
RELATIONSHIP TO PATIENT	PHONE NUMBER	RELATIONSHIP TO PATIENT	PHONE NUMBER

SERVICES

GEORGIA CANCER SPECIALISTS I, P.C. SUPPORTS THE USE OF MID-LEVEL PROVIDERS. YOU MAY BE SEEN PERIODICALLY BY A NURSE PRACTITIONER AND/OR PHYSICIAN ASSISTANT AND BILLED APPROPRIATELY.

Patient Signature

XX Patient Signature _____ **Date:** _____