SUNCOAST CANCER INSTITUTE
THE POWER TO CARE

NEW PATIENT INTAKE FORM

Patient Name: (First, Middle, Last)				Today's Date
Social Security Number	Date of Birth			Sex
Local Street Address	City	State	Zip	
Local Home Phone	Cell		Work/Other	
Other Street Address	City	State	Zip	
Email Address (*NOT* shared with anyone)				
Occupation	Employer			
City of Birth	State of Birth	Marital Status		
Preferred Pharmacy	Location		Phone	
Emergency Contact Person	Phone		Relationship to patient	

Primary Insurance	Secondary Insurance

How did you hear about our office?

- ☐ Physician Referral
- ☐ Insurance Provider
- ☐ Magazine/News/Media
- ☐ Internet (search engine/site?) _____
- ☐ Family or Friend (first & last name?) _____
- ☐ Other _____

Advance Directive / Living Will ☐ Has ☐ Does not have

Code Status / Do Not Resuscitate Order ☐ Full Code ☐ DNR ☐ Does Not Have

Medical Healthcare Surrogate / Durable Power of Attorney

☐ Has a Medical Healthcare Surrogate ☐ Does Not Have a Medical Healthcare Surrogate

Healthcare Surrogate's Name:_____

Name of referring physician:_____

Name of your Primary Care physician:_____

_____No primary physician ____Self-Referral ____Referred by family or friend ____Other

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Patient Consent for Receipt and Transmittal of Protected Health Information

I give permission to SUNCOAST CANCER INSTITUTE to Share: (Please check yes or no)

1. The following information on your **HOME** - **CELL** - **WORK** voicemail:

• Appointment Information	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Billing Information	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Medical Information	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Prescription Refills	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
• Authorizations or Referrals	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

☐ *Check here to include ALL above*

2. I give permission to Suncoast Cancer Institute to share only **appointment and billing information** with the following people listed below:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

3. I give permission to Suncoast Cancer Institute to share only **medical information** with the following people listed below: ☐ *Check here to include ALL above*

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Patient Name (printed):_____

Patient Signature:_____ Date: _____

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GENERAL CONSENT

1. I do hereby voluntarily consent to my care including examinations, tests, immunizations, vaccinations, regional or local anesthesia, routine procedures and other treatment by Suncoast Cancer Institute professionals and its assistants or consultants, as deemed necessary in their judgment.
2. I understand that blood may be taken from me for HIV testing without my further permission if a doctor, other professional, or an employee is exposed to my blood or bodily fluids.
3. If I do not understand any procedure or treatment or its risks or consequences, I have the right to question appropriate health care personnel.
4. I authorize the release to any party responsible for my care such information from my medical records as is required in order for Suncoast Cancer Institute and all entities providing services to obtain payment. This includes records of alcohol/drug abuse and or treatment records indicated testing, diagnosis or treatment for HIV infection or related problems, records of psychological or social services including communication made by the patient to the physician, social worker or a psychologist. This authorization shall be necessary only so long as to obtain payment or reimbursement and will end when payment or reimbursement is received.
5. I understand that Suncoast Cancer Institute is not liable for loss or damage to any personal property.
6. I understand the contents on this form and have read the form and my questions have been adequately answered prior to signing the form.

Patient Signature:_____

Today's Date:_____

FOR OFFICE USE ONLY: DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT:

Patient Name:_____

on _____ (date), Suncoast Cancer Institute office staff presented this acknowledgement of receipt of notice of privacy practices to above mentioned patient, who refused to provide a signature when requested.

Signature of office staff:_____