PACIFIC CANCER CARE **PATIENT INFORMATION**

5 Harris Ct. Bldg.T Suite 201
Monterey, CA. 93940

Acct # _____ **Date_____**

SSN: _____ **Sex: _____** **Marital Status: _____**

Date of Birth: _____ **Race: _____** **Age: _____**
First Name: _____ **Middle:_____** **Last: _____**
Physical Address: _____

Mailing Address: _____
Home Phone: _____ **Mobile: _____** **Work: _____**

Current Employment Status: _____
Employer:_____ **Address: _____** **City: _____** **Zip:_____**
Name of Doctor or Person who referred you to Dr.: _____

Emergency Contacts: _____ **Relationship:_____** **Phone: _____**

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EMAIL ADDRESS: _____

Advanced Directives

Living Will: ○ Yes ○ No **Durable Power of Attorney:** ○ Yes ○ No
DNR Yes ○ ○ No ◉ **PLEASE BRING A COPY WITH YOU!**

I give Pacific Cancer Care permission to electronically obtain my medication history Yes___ No___

INSURANCE INFORMATION

WE WILL NEED YOUR CURRENT INSURANCE & PRESCRIPTION CARDS, AND YOUR DRIVERS LICENSE. PLEASE GIVE TO RECEPTIONIST TO MAKE COPIES.

PRIMARY INSURANCE
Company: _____ **Address: _____**
Member ID# _____ **Group# _____**
Subscriber: Self___ Spouse___ Guardian ___
Subscriber's Name: _____ **DOB:_____**
Address: _____

SECONDARY INSURANCE

Company:_____ **Address: _____**
Member ID# _____ **Group# _____**
Subscriber: Self___ Spouse___ Guardian ___
Subscriber's Name: _____ **DOB:_____**
Address:_____ _____

It is our standard practice to enroll all patients in assistance programs. By signing below, you agree to allow our office to sign and submit your assistance application electronically.

I, the patient or guarantor, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by myself/patient and agree to pay my copays and deductibles at time of service. I authorize physician and clinic to release any medical information necessary to process claims. I also authorize my insurance claims/Medical Benefits to be paid directly to Pacific Cancer Care. In the event that my medical claim is denied, I authorize Pacific Cancer Care to initiate and file a complaint with the insurance commissioner.

PATIENT SIGNATURE:_____ **DATE:_____**

PROVIDER REPRESENTATIVE INITIALS: _____ **Rev. 3-26-19**