Atlanta Cancer Care
AFFILIATED WITH
NORTHSIDE HOSPITAL CANCER INSTITUTE
BUILT TO BEAT CANCER

PATIENT INFORMATION FORM

Patient Information

Date (M/D/Y):

First Name: Mid Name: Last Name: Suffix:(JR. Sr.):

Street Address: County:

City, State & Zip: Country:

Home Phone: Cell Phone:

Email:

Can message be left: ☐ Home ☐ Cell

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐ Other

Preferred Language:

Date of Birth (M/D/Y): SEX: ☐ Female ☐ Male

DEMOGRAPHICS: Which choice most closely reflects your individual recognition in your community? Race & Ethnicity are collected for statistical reporting to the US Government and the choices displayed are based solely on the Government Recommendations.

Race:
- ☐ American Indian or Native AK
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Pacific Islander/ Hawaiian
- ☐ Multiracial
- ☐ Unknown

Ethnicity:
- ☐ Hispanic/ Latino
- ☐ Not Hispanic or Not Latino
- ☐ Unknown

Nationality:
- ☐ American
- ☐ Brazilian
- ☐ British
- ☐ Canadian
- ☐ Chinese
- ☐ Cuban
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hispanic
- ☐ Indian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Mexican
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Saudi Arabian
- ☐ Vietnamese
- ☐ Other

Emergency Contact: Emergency Phone: Relationship:

Referring Physician: Primary Care Physician:

Do you have an Advance Directive? ☐ Yes ☐ No If no, would you like more information?

PATIENT INFORMATION FORM

Patient Employer

Occupation:

Employment Status: ☐ Full Time ☐ Not Employed ☐ Retired ☐ Disabled ☐ Part Time ☐ Self Employed ☐ Active Military

Effective Date of Employment (M/D/Y):

Retirement Date (M/D/Y):

Disabled Date (M/D/Y):

Employer/School:

Employer Address:

City, State & Zip:

Work Phone: Ext:

Other Responsible Party/ Spouse/ Significant Other

First Name: Mid Name: Last Name: Suffix:(JR. Sr.):

Relationship to Patient :

SEX: ☐ Female ☐ Male

Date of Birth (M/D/Y):

Street Address:

City, State & Zip:

Country:

Home Phone: Cell Phone: Work Phone:

Spouse Employment

Occupation:

Employment Status: ☐ Full Time ☐ Not Employed ☐ Retired ☐ Disabled ☐ Part Time ☐ Self Employed ☐ Active Military

Effective Date of Employment (M/D/Y):

Retirement Date (M/D/Y):

Employer/School:

Retirement Date (M/D/Y):

Employer Address:

City, State & Zip:

Work Phone: Ext:

Patient Insurance Information

First Name: Mid Name: Last Name: Suffix:(JR. Sr.):

Date of Birth (M/D/Y):

PATIENT INFORMATION FORM

First (Primary) Insurance Information

Carrier/Plan Name:

Group Name: Group Phone Name: Ext:

Group Number: Policy Number:

Claims Address: (back of insur. card)

City, State & Zip:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

SEX: ☐ Female ☐ Male

Insured's Name: (as printed on card):

Date of Birth (M/D/Y):

☐ HMO ☐ PPO ☐ POS

Payor ID (EDI#):

Second (Secondary) Insurance Information

Carrier/Plan Name:

Group Name: Group Phone Name: Ext:

Group Number: Policy Number:

Claims Address: (back of insur. card)

City, State & Zip:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

SEX: ☐ Female ☐ Male

Insured's Name: (as printed on card):

Date of Birth (M/D/Y):

☐ HMO ☐ PPO ☐ POS

Payor ID (EDI#):

Third (Tertiary) Insurance Information

Carrier/Plan Name:

Group Name: Group Phone Name: Ext:

Group Number: Policy Number:

Claims Address: (back of insur. card)

City, State & Zip:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

SEX: ☐ Female ☐ Male

Insured's Name: (as printed on card):

Date of Birth (M/D/Y):

☐ HMO ☐ PPO ☐ POS

Payor ID (EDI#):