

PATIENT INFORMATION FORM

PUTNAM COUNTY HOSPITAL CANCER AND HEMATOLOGY CENTER INFUSION CENTER

DATE: _____

LAST NAME: _____ FIRST NAME: _____ M.I. ____
ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____

SOCIAL SECURITY#: _____ DATE OF BIRTH: _____
SEX: _____ MARITAL STATUS: _____

HOME PHONE# _____ CELL PHONE# _____

*OK to leave detailed message on answering machine or voicemail? YES _____ NO _____

ARE YOU A VETEREN? YES _____ NO _____

PRIMARY CARE PROVIDER: _____

PRIMARY EMERGENCY CONTACT

NAME: _____
PHONE #: _____
RELATIONSHIP: _____

INDICATE THE INFORMATION THAT MAY BE DISCUSSED

___ APPOINTMENTS/SCHEDULING
___ MEDICAL TESTING RESULTS AND DIAGNOSIS

SECONDARY EMERGENCY CONTACT

NAME: _____
PHONE#: _____
RELATIONSHIP: _____

INDICATE THE INFORMATION THAT MAY BE DISCUSSED

___ APPOINTMENTS/SCHEDULING
___ MEDICAL TESTING RESULTS AND DIAGNOSIS

PRIMARY INSURANCE:

NAME OF INSURANCE COMPANY: _____ ID# _____
POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE:

NAME OF INSURANCE COMPANY: _____ ID# _____
POLICY HOLDER'S NAME: _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____

***WE WILL REQUEST TO MAKE A COPY OF INSURANCE CARDS FOR OUR RECORDS**

DO YOU HAVE AN ADVANCE DIRECTIVE? YES _____ NO _____

**PUTNAM COUNTY HOSPITAL
CANCER AND HEMATOLOGY CENTER
INFUSION CENTER**

I, _____ (patient name and date of birth), request that the following information be followed for the disclosure of my **Protected Health Information**.

Protected Health Information may include but not limited to: name, diagnosis, test results, dates of services as described in the **Notice of Privacy Practices**.

Please list name, phone number and relationship of whom we may disclose information to.

NAME	PHONE NUMBER	RELATIONSHIP

Please list phone number(s) that we may leave **PROTECTED HEALTH INFORMATION** on an answering machine/voicemail:

PHONE NUMBER(S): _____

NOTES:

***THIS DOCUMENT DOES NOT ALLOW THE PERSONS LISTED TO SIGN OR RECEIVE MEDICAL RECORDS.
A RELEASE OF INFORMATION FORM MUST BE SIGNED BY THE PATIENT OR THE POWER OF ATTORNEY**

***THIS DOCUMENT IS EFFECTIVE UNTIL TERMINATED OR CHANGED BY THE PATIENT**

PATIENT PRINTED NAME

PATIENT SIGNATURE AND DATE

MEDICAL HISTORY
PUTNAM COUNTY HOSPITAL CANCER AND HEMATOLOGY CENTER

TODAY'S DATE: _____

NAME: _____

DATE OF BIRTH: _____

PHARMACY: _____

Tobacco Use:

Currently Smoking (check all that apply):

___ Cigarettes ___ Pipe ___ Cigar ___ Smokeless Tobacco/Chewing Tobacco
 Packs per day? _____ Years? _____

Exposure to second hand smoke? Yes _____ No _____

Previous Smoking (check all that apply):

___ Cigarettes ___ Pipe ___ Cigar ___ Smokeless Tobacco/Chewing Tobacco
 Year quit? _____ Packs per day? _____ Years? _____

Alcohol Use:

___ None ___ Occasional ___ 1 drink per day ___ More than 1 drink per day

Have you ever been exposed to any of the following toxic chemicals (check all that apply):

- ☐ Cigarette smoke
- ☐ Asbestos
- ☐ Benzenes
- ☐ Aerosols
- ☐ Others _____

ALLERGIES:

(Please list any allergies to medications and/or foods)

NON-MEDICATION ALLERGIES:

(Please check all that apply)

___ Latex ___ Contrast Dye ___ Tape ___ Shellfish ___ Iodine ___ Other

(Please list type and relationship to patient)

[illegible]

SURGERIES:

(Please list all surgeries, include year if known)

[illegible]

MAJOR MEDICAL HISTORY:

(Please list your major medical history and illnesses, include year if known)

[illegible]

MEDICATIONS:

(Please list all medications including vitamins and dosage)

[illegible]