Patient Information Form

First Name: _____

Last Name: _____

Sex: ☐ Male ☐ Female

Marital Status: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____

Social Security #: _____

Employer: _____

Occupation: _____

Work Phone: _____

If Student, Name of School: _____

Language(s) Spoken: _____

Race: ☐ White ☐ Black ☐ Asian ☐ Hispanic
☐ Native Hawaiian ☐ Pacific Islander
☐ Native American or Alaskan Native
☐ Decline to Answer
☐ Other: _____

Spouse or Responsible Party:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Cell Phone: _____

Date of Birth: _____ Age: _____

Social Security #: _____

Employer: _____

Work Phone: _____

Person to Contact in Case of Emergency:

Permission to discuss my treatment, diagnostic tests and medical condition:

☐ Yes ☐ No

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____

Relationship to Patient: _____

Please bring your insurance card(s) and your prescription card with you to present to the receptionist when you arrive for your appointment.

Prescription Drugs: To better meet our patients' needs we can dispense some of the prescriptions as prescribed by our physician(s) here on our campus. We will bill your pharmacy insurance and charge the applicable co-pay. Please understand that you are not obligated to have prescriptions filled here and that you have the option of receiving your medications from the pharmacy of your choice. We would be happy to facilitate this for you.

Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322 or www.mbc.ca.gov

Date: _____

Patient or Guardian Signature: _____

Guardian Name: _____

Relationship to Patient: _____

Request for Release of Medical Records & Pathology Material

URGENT

Physician/Hospital Name: _____

_____

Address: _____

_____

_____

Dates of Hospitalization: _____ thru _____

Date: _____

Patient Name: _____

Date of Birth: _____

Patient or Guardian Signature: _____

Guardian Name: _____

Relationship to Patient: _____

I hereby request any and all of the following medical records in your possession:

- ☐ Imaging Reports
- ☐ Laboratory & Pathology Results
- ☐ Pathology Material
- ☐ Physicians Office Records
- ☐ Hospital Records
- ☐ HIV Test Results
- ☐ Mental Health Records Protected by Lanterman-Petris –Short Act
- ☐ Other: _____

The authorization is effective now and will remain in effect until one year from date signed.

If not signed by patient, please indicate the relationship:

- ☐ Parent or guardian of a minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of a deceased patient
- ☐ Spouse or person financially responsible –where information is solely for the purpose of processing an application for dependent health care coverage

For mental health records only:

Physician Signature: _____

Date: _____

To be released and faxed to:

Comprehensive Blood & Cancer Center
6501 Truxtun Avenue
Bakersfield, CA 93309
Fax: **(661) 322-7027**

Release of Patient Medical Information

_____ *(Initial)* I give the physicians and staff of CBCC permission to discuss my treatment, diagnostic tests, medical condition with the following individuals:

_____ *(Initial)* I give the physicians and staff of CBCC permission to discuss my Mental Health Records protected by Lanterman-Petris –Short Act with the following individuals:

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

I understand that if I wish to add or delete individuals from this list that I must notify CBCC in writing.

I authorize CBCC to leave test results on my voice mail:

☐ Yes ☐ No

Home Phone: _____

Mobile Phone: _____

I authorize CBCC to fax test results to me:

☐ Yes ☐ No

Fax Number: _____

I understand that if my telephone or fax number changes from this list that I must notify CBCC in writing.

This is an indefinite consent form unless otherwise specified.

Date: _____

Patient Name: _____

Date of Birth: _____

Patient or Guardian Signature: _____

Guardian Name: _____

Relationship to Patient: _____