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: _____

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: _____

Preferred Method of Contact:

☐ Phone ☐ Text ☐ Email

By agreeing to receive text messages from CBCC, you acknowledge that standard text messaging rates from your wireless carrier may apply.

Person to Contact in Case of Emergency:

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

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 Responsible Party Signature: _____

Responsible Party 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 Responsible Party Signature: _____

Responsible Party 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

_____ 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:
(Initial)

_____ Do not release medical information.
(Initial)

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone: _____

Release Information to:

Name: _____

Relationship: _____

Phone:

Release Information to:

Name: _____

Relationship: _____

Phone:

This is an indefinite consent form unless otherwise specified.

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

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Attendance Policy

CBCC strives to make everyone's visit comfortable and timely while offering the best quality of care. In an effort to respect everyone's schedule and maximize the time our patients spend with their provider/medical care team during their visits, our attendance policy is as follows:

1. Please arrive 15-minutes before your first scheduled appointment to allow ample time for check-in.
   New Patients: CBCC requires all first-time patients to arrive at least 30-minutes before your first appointment time in order to ensure that we have all necessary paperwork and documents on file during your new-patient appointment.

2. **Patients who arrive late *(less than 15-minutes BEFORE the scheduled appointment time)* may be required to reschedule**. Patients with three tardies and/or missed appointments may result in a full discharge from the clinic.

3. We understand that life happens. We require that all appointments are confirmed, canceled, or rescheduled at least 24 business hours before your appointment.

4. Occasionally, patients require unexpected, immediate attention throughout treatment. In such situations, please call us at **(661) 322-2206** before coming to the facility in an effort to expedite the scheduling of your visit and limit your wait time to the best of our ability. ***CBCC does not offer walk-in appointments***.

5. **Visitors**: Space at CBCC is limited. Please only bring 1 (one) visitor with you to your appointment.
   Radiation Exposure Notice: For safety reasons, CBCC prohibits visitors who are pregnant and/or children under 16 years old.

We look forward to serving you and making your visit a pleasant one.

Your signature below indicates that you have read and agree to CBCC's Attendance Policy.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____

Code of Conduct

CBCC is committed to ensuring a safe, secure and respectful environment for everyone – patients, visitors, physicians, providers, healthcare teams and employees.

It is our expectation that all individuals will demonstrate civil and respectful behavior while on our premises.

We expressly prohibit:

- Abusive language including threats and slurs
- Sexual harassment
- Physical assault
- Weapons

To maintain a safe, secure and respectful environment for all, we reserve the right to take appropriate measures to address abusive, disruptive, inappropriate or aggressive behavior.

Your signature below indicates that you have read and agree to CBCC's Code of Conduct.

Date: _____

Patient Name: _____

Patient or Responsible Party Signature: _____

Responsible Party Name: _____

Relationship to Patient: _____