Roger Williams MEDICAL CENTER

Cancer Center

50 Maude Street
Providence, RI 02908
(401) 456-2077 Phone
(401) 456-5765FAX

Today's Date: _____

Patient Name _____ **Date of Birth** _____

Address _____ **Soc Sec #:** _____
Address & Apt #

Phone #: Home ( ) Cell ( )
May we leave messages at this number? Yes No

_____
City, State, Zip Code

Marital Status: **Married** **Single** **Divorced** **Widowed**

Religious Pref. _____ **Sex: (circle one)** Male Female

Do you have: **Advanced Directive** (Living Will for Medical Purposes) **Yes** ( ) Please provide a copy for your medical file.
No ( ) Would you like additional information? Y N

Durable Power of Attorney Yes No **Name:** _____

NEXT OF KIN / EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Address _____ **Phone #:** ( )
Address & Apt #

_____
City, State, Zip Code

EMPLOYMENT STATUS

If Not currently employed Choose One:

Employer Name: _____ **Retired:** _____
Date

Address _____
Address & Apt #

Disabled: _____
Date

_____
City, State, Zip Code

Unemployed: _____

Phone #: ( ) --

INSURANCE

Primary _____ **Policy Holder Name** _____

Secondary _____ **Policy Holder Name** _____

PHYSICIANS

	Name	Address
Primary/Family		
Cardiologist		
Surgeon		

PHARMACY

Name: Phone Number:

Roger Williams Medical Center
Cancer Center

Patient Name
Date of Birth

_____

PAST MEDICAL HISTORY

Have you been diagnosed with: (✓ all that apply)

	Diagnosed When?		*Diagnosed When?*		*Diagnosed When?*
☐ Heart Attack/Disease	_____	☐ Ulcers	_____	☐ AIDS	_____
☐ Stroke	_____	☐ Kidney/Urinary Problems	_____	☐ Hepatitis	_____
☐ Diabetes	_____	☐ Thyroid	_____	☐ Bleeding disorders	_____
☐ High Blood Pressure	_____	☐ Arthritis	_____	☐ Reactions to Anesthesia	_____
☐ Cancer	_____	☐ Psychiatric Disorder	_____	☐ Other_____	_____
☐ Asthma	_____	☐ Depression	_____	☐ Other_____	_____
☐ Lung Problems	_____	☐ Tuberculosis	_____	☐ Other_____	_____

FAMILY HISTORY

Has a family member been diagnosed with: (✓ all that apply)

	Relationship		*Relationship*		*Relationship*
☐ Heart Attack/Disease	_____	☐ Cancer	_____	☐ Kidney/Urinary Problems	_____
☐ Stroke	_____	☐ Lung Problems	_____	☐ Bleeding disorders	_____
☐ Diabetes	_____	☐ Ulcers	_____	☐ Reactions to Anesthesia	_____
☐ High Bleed Pressure	_____				

SOCIAL HISTORY

Alcohol (amount per week): _____

Smoking (amount per week): _____ Packs for _____ Years Quit _____ Year _____

CURRENT MEDICATIONS & Dosages

_____

_____

_____

_____

ALLERGIES: _____

REVIEW OF SYSTEMS: DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Current Height _____ Current Weight _____

☐ Headaches	☐ Loss of Appetite	☐ Rectal Bleeding	☐ Muscle Problems
☐ Chest Pain	☐ Vomiting	☐ Difficulty Passing Urine	☐ Ear, Nose or Throat Problems
☐ Shortness of Breath	☐ Nausea	☐ Burning/Frequent Urination	☐ Nerve Problems
☐ Chronic Cough	☐ Constipation	☐ Hormonal/Glandular Problems	☐ Social Problems
☐ Abdominal Pain	☐ Diarrhea	☐ Skin Problems	☐ Psychiatric Problems
☐ Unexplained Weight Loss	☐ Recent Change in Bowel Function	☐ Blood/Lymph Gland Problems	

Roger Williams Medical Center

CharterCARE Health Partners

St. Joseph Health Services of Rhode Island

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Identification

**** You May Refuse to Sign this Acknowledgement ****

I, _____, have received a copy of this Health Care Provider's Notice of Privacy Practices.

Please Print Name:

_____ Date: _____

Signature:

_____

Patient's Representatives:

1.) Name:
_____

Relationship: _____ Phone: _____

2.) Name:
_____

Relationship: _____ Phone: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment
could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

The purpose of this form is to obtain acknowledgement of receipt of our Notice of Privacy Practices by the patient, or to document our good faith effort to obtain acknowledgement.

Please place the completed form with the patient's records for this encounter.