

# Cancer Center

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

Today's Date: \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
Address & Apt #

Soc Sec #: \_\_\_\_\_

Home ( )

Phone #: \_\_\_\_\_  
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 \_\_\_\_\_  
Address & Apt #

Phone #: ( ) \_\_\_\_\_

\_\_\_\_\_  
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

Phone #: ( ) -- \_\_\_\_\_

Unemployed: \_\_\_\_\_

## ***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)

	<u>Diagnosed When?</u>		<u>Diagnosed When?</u>
<input type="checkbox"/> Heart Attack/Disease	_____	<input type="checkbox"/> Ulcers	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Kidney/Urinary Problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Psychiatric Disorder	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Lung Problems	_____	<input type="checkbox"/> Tuberculosis	_____
		<input type="checkbox"/> AIDS	_____
		<input type="checkbox"/> Hepatitis	_____
		<input type="checkbox"/> Bleeding disorders	_____
		<input type="checkbox"/> Reactions to Anesthesia	_____
		<input type="checkbox"/> Other _____	_____
		<input type="checkbox"/> Other _____	_____
		<input type="checkbox"/> Other _____	_____

## FAMILY HISTORY

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

	<u>Relationship</u>		<u>Relationship</u>
<input type="checkbox"/> Heart Attack/Disease	_____	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Lung Problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Ulcers	_____
<input type="checkbox"/> High Bleed Pressure	_____		
		<input type="checkbox"/> Kidney/Urinary Problems	_____
		<input type="checkbox"/> Bleeding disorders	_____
		<input type="checkbox"/> Reactions to Anesthesia	_____

## SOCIAL HISTORY

Alcohol (amount per week): \_\_\_\_\_

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

## CURRENT MEDICATIONS & Dosages

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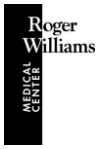
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## **ALLERGIES:** \_\_\_\_\_

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

Current Height \_\_\_\_\_      Current Weight \_\_\_\_\_

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



# 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.**