Central Kansas Cancer Center

1133 College Avenue, Bldg. E, Suite 140, Manhattan, KS 66502

Please use black or blue ink Date_____

(PLEASE PRINT)

~ PATIENT INFORMATION ~

Name_____ **Soc. Sec. No.** _____
Last First Middle Initial

Address_____**County**_____

City_____ **State**_____ **Zip**_____

Home Phone _____ **Cell Phone** _____

E-mail address_____ **Work Phone**_____

Employer _____ **Occupation**_____

Preferred method of contact: ☐ Home phone ☐ Cell phone ☐ Business phone ☐ Mail

Sex ☐ M ☐ F **Age**_____ **Birthdate**_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnic Background ☐ Not Latino/Hispanic ☐ Latino/Hispanic ☐ I decline to answer

Race_____ ☐ I decline to answer **Preferred Language**_____

~ CONTACT INFORMATION ~

Spouse/Significant Other _____
Last First Middle Initial

Phone (H)_____ (C)_____ (W) _____

Emergency (if different from Spouse/Significant Other) _____
Last First

Relationship _____Phone (H)_____(C)_____ (W)_____

Secondary contact _____
Last First Middle Initial

Relationship _____Phone (H)_____ (W) _____ (C)_____

~ PHYSICIAN INFORMATION ~

Primary Care Physician _____ Phone _____

Address _____

Surgeon_____ Phone _____

Address _____ Phone _____

Medical Oncologist_____ Phone _____

Address _____

Other Physician/Specialist_____ Phone _____

Specialty _____ Address _____

~ PHARMACY ~

Name _____ **Phone**_____

Address_____

Do you have a Durable Power of Attorney for medical and/or financial decision making? ☐ Yes ☐ No
(If yes, please provide a copy for our records.)

Do you have an Advanced Medical Directive or DNR? ☐ Yes ☐ No (If yes, please provide a copy for our records.)

THANK YOU!

Revised 08-2017