PATIENT DEMOGRAPHICS

Please complete and email or fax to angie@cancerimmunebio.com

(251)943-9724

Date:_____

Name:_____Date of Birth_____

Mailing Address:_____

City:_____State:_____Zip:_____

Hom Phone:_____Cell:_____

Email:_____

Contact Preference: □Phone □Mail □E-Mail □No Contact

Social Security #:_____Height:_____ft. _____in. Weight_____lbs.

Marital Status:_____ Gender: _____

Language: □English □Spanish □Mandarin □German □French □Italian □other_____

Race: □White □Black □Hispanic □Asian □Other_____

Smoking Status: □ Every day smoker □ Some day smoker □Former Smoker □Non-Smoker

Employer:_____

Job Title:_____

Employer Phone:_____

Primary Diagnosis:_____

Date pf Diagnosis:_____

ALLERGIES:_____

_____

Please list of your current medications/supplements:

_____

_____

_____

_____

_____

_____

Emergency Contact Name:_____

Emergency Contact Phone:_____

Emergency Contact Relation:_____

Your preferred Imaging facility: _____

Address: _____

Telephone: _____

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Do you have an aneurism clip, pacemaker or difibrillator?_____

Are you allergic to IV contrast?_____

Do you have any metal in your body?_____

Do you have a Port or Picc line?_____

What is your preferred laboratory facility?_____

Address: _____

Telephone: _____

What is the name, telephone number and location of your preferred pharmacy?

Name:_____(_____)_____

Location:_____

We now offer in office Consults with DR. Williams at our Atlanta Georgia office. Please indicate if you prefer telephone or in office consultations: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage or any public agency and its agent to determine benefits for services provided or benefits for related services.

I agree to pay all costs of collections, including reasonable attorney's fees and I further hereby waive all rights of exemption as to personal property under the Constitution and Laws of the State of Alabama.

Signature of Patient or Responsible Party:_____

Date :_____

Witness:_____Date:_____