Compass Health
SETTING A NEW DIRECTION IN HEALTH CARE
2175 Coolidge Road
East Lansing, Michigan 48823

Patient Information for Radiation Oncology Consultation

Please complete this form prior to your consultation appointment with your Radiation Oncologist.

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Sex: ☐ M ☐ F

Race: ☐ African American/ Black ☐ Asian ☐ Caucasian/White ☐ Greek ☐ Hispanic ☐ Indian ☐ Middle Eastern
☐ Native American Indian ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Prefer Not to Answer

Preferred Language: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer Not to Answer

Emergency Contact:	**Guarantor / Responsible Party:**
Name: _____	Name: _____
Relationship:_____	Relationship:_____
Address _____	Address _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone:_____	Phone:_____

Primary Insurance: _____ID#: _____GRP:_____

Subscribers Relationship to Patient: ☐ Self ☐ Spouse ☐ Other: _____

Subscriber's Name: _____ SSN#: _____ DOB: _____

Subscriber's Employer or Former Employer: _____

Secondary Insurance: _____ID#: _____GRP:_____

Subscribers Relationship to Patient: ☐ Self ☐ Spouse ☐ Other: _____

Subscriber's Name: _____ SSN#: _____ DOB: _____

Subscriber's Employer or Former Employer: _____

Patient Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Advanced Directives: Please check all that apply: ☐ Living Will ☐ Do Not Resuscitate (DNR)
☐ Healthcare Proxy: Name and Phone Number of Healthcare Proxy:_____

If any are checked, please bring a copy with you to your consultation appointment.

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Provider / Care Team Information

Patient Name: _____ Date of Birth: _____

Referring Physician: _____

Address: _____

_____

Phone: _____ Fax: _____

Primary Physician: _____

Address: _____

_____

Phone: _____ Fax: _____

Medical Oncologist: _____

Address: _____

_____

Phone: _____ Fax: _____

Surgeon: _____

Address: _____

_____

Phone: _____ Fax: _____

How did you hear about us? ☐Physician ☐Family ☐ Friend ☐Website ☐ Advertisement ☐Other

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Authorization for Use or Disclosure of Protected Health Information

By signing this form, I authorize Compass Healthcare, PLC to use and disclose my Protected Health Information (PHI) in the following manner:

Share my Protected Health Information with:
(Please CIRCLE and INITIAL applicable authorization)

_____ Spouse: Spouse's Name: _____

_____ Parent/siblings/child(ren)/guardian: Please provide applicable names: _____

_____

_____ The following person(s) _____

_____

_____DO NOT DISCLOSE MY PHI WITH ANYONE

Disclose my protected health information for the following reasons:
(Please CIRCLE and INITIAL applicable authorization)

_____ To leave an appointment reminder on my answering machine/service
_____at home _____at work

_____To leave a message on your answering machine to return a call
_____at home _____at work

_____To leave a message with a family member/co-worker to return a call
_____at home _____at work

_____DO NOT DISCLOSE MY PHI FOR ANY REASON STATED ABOVE

_____

Patient/Guarantor Signature *Today's Date*

_____

Printed Patient/Guarantor Name