CANCER SERVICES

505 E. Perkins Ave., Sandusky, OH 44870 • (419) 626-4548 or (800) 401-9054
www.freecancerservices.org Fax: (419) 502-0222

CLIENT INFORMATION FORM

1. Name: ____Phone: _______________________________

Address: _______________________________________City: ________________________________

State: _____Zip:__________County: ____________E -mail address: _____________________________

2. Birth Date: ____________ Age: ___ Female: ___ Male: ___ Married: ___ Single: ___ Div: ___ Widow:___

3. Contact living at home: _______________________________________Phone: ____________________

Relationship to Client: _______________________________________

4. Contact not living at home: __________________________________ Phone: ____________________

Relationship to Client: _______________________________________

Physician and Diagnosis:

1. Physician/Oncologist: ____
name/s address phone

2. Diagnosis/Type of Cancer: ___________________________Date of Diagnosis: ____________________

3. Are you receiving: Chemo: __Radiation: ___Date therapy began or will begin: _______________________

Assistance or Program *Requested: (Please check appropriate areas)*

A. ___Medication Assistance

B. ___Nutritional supplements: (Boost, Ensure, Carnation Instant Breakfast, etc.)

C. ___Mileage Reimbursement: (.20 a mile, parking and turnpike tolls)

D. ___Durable Equipment: (Wheelchairs, walkers, bedside commodes, shower chairs, etc.)__________________

E. ___Other: (Wigs, hats, turbans, breast prosthesis, bras, dressings, tapes, incontinent supplies, etc.)______________

F. ___ Support Groups: A team of caring and supportive people offering encouragement and non-medical support to cancer patients and their families.

***Additional financial information will be needed if A, B or C is checked.**

Do you have health insurance:

1. Medicare? Yes ___ No ___ Part A___ Part B___ Part D___ Medicaid? Yes___ No___

2. Other insurance: ____Are you a Veteran? Yes ___ No ___

3. Do you have any Rx drug plan? Yes ___ No___ Name of drug plan: _______________________________

How did you hear about Cancer Services? ____

Patient's Signature____**Date**_____________

or Authorized representative_____________________________________**Date**_____________