



WEST
CANCER CENTER
& RESEARCH INSTITUTE

Patient Information

West Cosmetic & Reconstructive Surgery

General Patient Information:

Patient Name: _____ Date of Birth: _____

SSN: _____ Patient Mailing Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Spouse (Next of Kin): _____ Relationship: _____ Phone: _____

Employer: _____ Work Phone: _____

The below information will be used to contact you. Please only provide information for any method you prefer West Cancer Center use for contact (e.g., work phone, mobile phone).

Email Address: _____ Home Phone: _____

Work Phone: _____ Mobile Phone (voice and text): _____

Contact Preference: Home / Work / Mobile/ Email

Insurance Information:

Primary Pharmacy: _____ Phone: _____

Pharmacy Cross Streets or Address: _____

Primary Insurance: _____ Policy Holder: _____ Policy Holder DOB: _____

Secondary Insurance: _____ Policy Holder: _____ Policy Holder DOB: _____

**Please provide a copy of your insurance card upon arrival.*

Information Required by Federal Government:

Race: Caucasian/White African American/Black American Indian Asian

Other _____

Ethnic Background: Hispanic Non-Hispanic

Preferred Language: _____

How did you hear about us? Physician Family/Friend Internet Search Social Media Other

If physician, may we thank them for their referral?

Name: _____

Do you need language translation assistance? Yes No

Do you need interpreter aids or assistance? Vision Hearing Other

Do you require a physical accommodation? Yes No

If Yes, please let us know what type of accommodation is required. _____

Advanced Directive for Medical Care (Living Will):

Do you have a Living Will? Yes No

I acknowledge that if I have a Living Will or any form of Advanced Directives, I should inform West Cancer Center and present a copy even if one is created after my initiation of care.

Gender Information:

For Clinical Use Only (please answer if applicable).

What sex were you assigned at birth or what is your legal sex?

Female Male

What is your current gender identity?

Female Male Trans female to male Trans male to female Questioning/Unsure

Decline to state Other _____

Patient Representative Identification

By law, the HIPAA Privacy Rule Prohibits West Cancer Center from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. Persons involved in your care or payment for care, such as a family member or caretaker may have access to your health information related to their involvement unless you indicate otherwise. In addition, your legal representative may access or receive your health information on your behalf.

Please list ALL PERSONS you wish to have access to your Protected Health Information (PHI): (i.e. those making appointments or checking on test results)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Can we discuss your bill with the above individuals? Yes No

If no, list individuals below whom we can discuss your bill.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Please list your Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

NOTE: In an Emergency, HIPAA permits release of PHI as necessary for informing your Emergency Contact of your location and condition.

If applicable, please list your Legal Representative:

Name: _____ Phone: _____ Relationship: _____

By what authority is this person your Legal Representative? (Please check one)

- Next of Kin Guardian General Power of Attorney Health Care Power of Attorney

PLEASE NOTE: In order for us to disclose your Private Health Information, the above representatives must be able to provide up to two (2) patient identifiers and documentation of legal representation.

Patient/Patient Representative Signature: _____

Date: _____



Clinical History

Reason for your visit? _____

Is this due to an accident? Yes No If yes specify: _____

Is the accident job relate? Yes No If yes date: _____

Past/Present Illness:

	Yes	How long?		Yes	How long?
Heart and Blood Vessels			Skin		
Anemia			Psoriasis		
Angina			Skin Condition(s)		
Blood Clot			Kidney/Bladder		
Chest Pain			Kidney Disease		
Deep Vein Thrombosis (DVT)			Kidney Stones		
Heart Attack			Urinary Tract Infection		
Heart Disease/Failure			Blood Disorders		
High or Low Blood Pressure			Bleeding with tooth		
Irregular Heartbeat			Blood Clots/Clotting		
Peripheral Vascular Disease			Easy bruising		
Rheumatic Fever			Immune System		
Stent Placement			Other Collagen Vascular		
Stroke/TIA			Human Immune Virus		
Brain and Nerves			Lupus		
Glaucoma			Joint/Skelton		
Migraines			Arthritis		
Multiple Sclerosis			Rheumatoid Arthritis		
Parkinson's Disease			Endocrine		
Seizures or Epilepsy			Diabetes or Sugar		
Lungs			Thyroid Disease or		
Allergies			Psychological		
Asthma			Anxiety		
Chronic Bronchitis			Depression		
Emphysema/COPD			Psychiatric Treatment		
Pneumonia			Other		
Pulmonary Embolism			Birth Defects / Birth		
Sleep Apnea			GYN Problems		
Tuberculosis (TB)			Hepatitis/Liver Disease		
Stomach/Intestines			HIV		
Colitis			Jaundice		
Crohn's Disease			Sinusitis		
Diverticular Disease			Vision Problems		
Gall Bladder Disease			Other:		
Kidney / Bladder Trouble			Other:		
Pancreatitis			Other:		
Recent Weight Loss / Gain			Other:		
Ulcers of Stomach or			Other:		

Personal Cancer History:

Have you been treated for cancer? Yes No

Caner Type		Yes/No	Date Treated	Treating Physician	Where?
	Did you receive chemotherapy?				
	Did you have surgery?				
	Did you have radiation?				

Past Surgeries/Significant Medical Events

None: (please check box if none)

Surgery/Event Type	Date	Hospital Performed	Surgeon Name

Are you under the care of a cardiologist? Yes No Doctor Name: __

Do you have any surgical hardware (please check yes for all that apply)?

Hip Valve(s) Pacemaker Defibrillator Aneurysm Clip

Mechanical Stimulating Device (Neuro Stimulator, Infusion Pump, etc) Other _____

Have you ever had a colonoscopy? Yes No If yes, when? _____ Where? _____

Have you ever had a mammogram? Yes No If yes, when? _____ Where? _____

Have you ever had polyps? Yes No If yes, when? _____

Have you ever had local anesthesia for dental work or a minor surgery? Yes No

If yes, did you have a reaction? _____

Please list any other physicians you currently see:

Physician Name	Specialty
_____	_____
_____	_____
_____	_____

Allergies and Reactions:

Are you allergic to latex? Yes No

Are you allergic to contrast IV? Yes No

Have you had any vaccinations? Yes No

If yes, which? _____

Have you ever had local anesthesia for dental work or a minor surgery? Yes No

If yes, did you have a reaction? _____

List any allergies and reactions:

Allergy	Type of Reaction
_____	_____
_____	_____
_____	_____

Social History:

Do you or did you ever smoke? Current Former Never

If current, estimate how many packs a day: _____ If former, how many years? _____

Do you vape? Current Former Never

Do you drink alcoholic beverages? Yes No If yes, how many drinks per week? _____

Do you have a history of recreational drug use? Yes No If yes, what type? _____



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Patient Privacy Notice Acknowledgement:

I acknowledge that **West Cancer Center's Notice of Privacy Practices** has been made available to me.

*This packet is available on the West Cancer Center website, westcancercenter.org,
and available for print at all front desk locations by request.*

Patient or Patient Representative Signature: _____

Date: _____