



# CANCER SERVICES

505 E. Perkins Ave., Sandusky, OH 44870 • (419) 626-4548 or (800) 401-9054  
[www.freecancerservices.org](http://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 \_\_\_\_\_