Vantage Oncology

St. Bernardine Radiation Therapy Center
401 E Highland Ave, Ste D
San Bernardino, CA 92404
(909) 475-2700

PATIENT INFORMATION

_____ _____/_____/_____ _____
First Name MI Last Name Date of Birth Age

_____
Address Apt# City State Zip

_____
Home Phone Work Phone Cell or Message Phone

Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing. Please only list phone numbers that you wish to be contacted at.

Social Security # (*optional):* _____ Sex: **M F** Marital Status: **S M W D**

Retired: **N Y** _____ Disabled: **N Y** _____ From what company?_____
Date Date

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice? _____ **Yes** _____ **No**

NOTE: If NO, Patient or Caregiver must immediately notify staff if Patient is admitted to a hospital, SNF, Convalescent Home, or Hospice.

_____
Name of Facility Phone

_____
Address City State Zip

INSURANCE INFORMATION

_____
Primary Insurance Medical Group (HMO) ID# Group #

_____/_____/_____
Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

_____
Secondary Insurance Medical Group (HMO) ID# Group#

_____/_____/_____
Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

_____
Primary Care Physician Phone

_____
Referring Physician Phone

EMERGENCY CONTACT

_____
Name Phone Relationship

Attention: Emergency Contact will only be contacted in the case of a true emergency unless this same phone number is listed above in which case it may be used to contact you for treatment or payment purposes.

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Patient/Guardian Signature _____ **Date** _____