

thesecondopinion

provided by the Regional Cancer Foundation

PATIENT QUESTIONNAIRE

Please fill out and return as soon as possible, along with your **Patient Registration and Authorization form** and a completed copy of your **Release of Medical Information Form**:

Name: _____ Date: _____

Phone number(s): _____ E-mail address: _____
Home Mobile

Type of Cancer: _____

How did you hear about our service? _____

Please check appropriate box below.

I will will not need the help of translator services.

Which language (dialect)? _____

The information below is used only to provide statistics to potential funding organizations. **No names will be used.**

1. Age: _____ Gender: _____ County of Residence: _____

2. **Ethnic identity:** *(Please circle each identity that applies to you)*

African American

Latino/Hispanic

Pacific Islander

Native American

White

Other

Asian

Mixed

3. *(Please circle one)* **Are you:** Single Married Widowed Divorced

4. **Number in household:** **Number of Children:** **Ages:** _____

(Please circle one below)

5. **Are you:** Currently employee Retired Temporarily disabled Permanently disabled

6. **Occupation** (current or past) _____

7. **Are you covered by any of the following:** *(Please circle all that apply)*

(All consultative services are completely free of charge, we will not bill you or your insurance company)

Medical insurance

Medi-Cal

Medicare

8. **Does your health insurance pay for second opinions?** _____

9. **Under what circumstances?** _____

10. **Where are you receiving your cancer care?:** *(Please circle all that apply)*

Private Office

County Hospital/Clinic

Kaiser *(location?)* _____

University Clinic

Other HMO

Thank you for providing this information to The Second Opinion, provided by the Regional Cancer Foundation

