223 Riverview Dr. Suite J
Danville, VA 24541
(434) 791-3227
(434) 791-4815 – FAX
www.danvillevacancer.org
hope@gamewood.net

CONFIDENTIAL CLIENT APPLICATION FORM

Client's Name_____

Address_____

City_____**State**_____**Zip Code**_____

Primary Phone _____**Date of Birth:** _____

Type of Cancer_____ **Date of Diagnosis**_____

Oncology Physician_____**Phone**_____

Oncologist's Address_____

What type of treatment are you receiving? (Please circle): Chemo Radiation Other_____

Where are you taking your treatments? (Medical Facility): _____

Are you receiving any other assistance? (Please circle): Yes No

If *yes*, from what organization? _____

Does patient have? (Please circle): Medicare Medicaid SSI Disability Pension

Unemployment Income Veteran Employer Insurance Other_____

***Do you have cancer insurance? (Aflac, etc.):** Yes No

Is there any other authorized person that we may contact regarding your care? If so list below:

Name_____ **Phone**_____

I, _____do hereby authorize Danville-Pittsylvania Cancer Association, Inc. its employees and/or volunteers to contact my physicians, medical facilities, and pharmacies to confirm my cancer related needs. I certify that all of my information is true and complete to the best of my knowledge. I understand that DPC may revoke my services at any time. I will notify DPC if any of my information changes. Any act of fraud will result in immediate suspension of services and may result in civil action or criminal prosecution. This release is in accordance with any and all healthcare laws.

Signature_____ **Date**_____

DPC Rep._____ **Date Received**_____

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***<u>The following questions are for statistical purposes only</u>*:**

Total household income: _____

Ethnicity (please circle): White African American Hispanic/Latino

Native American/American Indian Asian/Pacific Islander

Other _____

Gender (please circle): Male Female

Number of people in household (including dependents): _____