Sierra County Cancer Assistance

HC32 Box 8174
Truth or Consequences, NM 87901
575-740-3971 or srfoxie@gmail.com

Patient Signup Information

Name: ____

Physical Address: __________________________City: ______________State: ______Zip:________

Mailing Address:___________________________City:_______________State:______Zip:________

Home Phone: _____________________________ Cell Phone:________________________________

Date of Birth: ________________________ Spouses Name:__________________________________

Care Giver Name:_______________________ Phone Number: _______________Cell:____________

Requested Assistance Needed:____

Your Current Condition: ____

Physician Name: ___________________________________ Phone Number:____________________

Health Care Provider: ______________________________ Phone Number:____________________

Emergency Contact: ________________________________Phone Number: ____________________

E-mail address: ______________________________ Do you Smoke? ______Yes _______No

Why do you feel you should get assistance from us?____

Where did you hear about us? ____

Do you need wheelchair vehicle assistance? ____

Special needs or Items required for assistance: ____

How frequently do you feel Sierra County Cancer Assistance will be required?

Weekly_____________ Monthly______________ Other _______________

Date:______________________________ Signature of Patient:_______________________________

If unable to sign designated Guardian Signature: ___________________________Date:____________

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