



10 Oak Street, Southampton, NY 11968

This form must be completely filled out and include a doctor's note of diagnosis in order to be eligible for services. All information submitted is confidential.

LUCIA'S ANGELS INTAKE FORM

- NAME: _____ DATE: _____
- DATE OF BIRTH: _____ AGE: _____
- MAILING ADDRESS: _____ TOWN: _____
- ZIP: _____ COUNTRY OF CITICENSHIP: _____
- PHONE: _____ CELL: _____ EMAIL: _____
 Please include my email in your mailing list. Please keep my email confidential.
- RACE: _____ ETHNICITY: _____
- LEVEL OF EDUCATION: _____ SPOUCE/PARTNER NAME: _____
- OTHER HOUSEHOLD MEMBERS AND AGES: _____
- OCCUPATION: _____ EMPLOYMENT STATUS: _____
- PAST COLLECTIVE HOUSEHOLD INCOME: _____
- PRESENT COLLECTIVE HOUSEHOLD INCOME: _____
- CURRENT PATIENT INCOME: _____ PAST PATIENT INCOME: _____
- DIAGNOSIS: TYPE OF BREAST CANCER: _____
- DATE: _____ STAGE: _____
- HOSPITAL: _____ SURGEON: _____ TYPE: _____

- TYPE OF TREATMENT: _____
- ONCOLOGIST: _____ RADIATION ONCOLOGIST: _____
- FAMILY HISTORY OF BREAST CANCER: YES NO
- INSURANCE CARRIER: _____
- MEDICAID/MEDICARE: YES NO
- HOW DID YOU HEAR ABOUT US? _____

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