Date: ______________

Allied Hematology Oncology Associates

Patient Name: ______________ Date of Birth: __________ Age______ M ☐ F ☐

Social Security #: ______________ S ☐ M ☐ W ☐ D ☐ Religion: ______________

Mailing Address: ______________ City/State: ______________ Zip: ________

Home Phone: ( ) __________ Employer: ______________ Work Phone: ( ) __________

Emergency Contact: ______________ Phone: ( ) __________

Family Doctor: ______________ Who referred you to us?: ______________

Please list individuals we are authorized to speak with regarding your care/account: (Include the last four digits of their social security number *or* their mother's maiden name for verification purposes. Thank you.)

Name: ______________ Last Four Digits of SS# or Mother's M.N.: ______________

Name: ______________ Last Four Digits of SS# or Mother's M.N.: ______________

Name: ______________ Last Four Digits of SS# or Mother's M.N.: ______________

SPOUSE / PARENT / GUARDIAN / RESPONSIBLE PARTY:

Name: ______________ Date of Birth: ______________ (REQUIRED) M ☐ F ☐

Social Security #: ______________ Address: ______________

City/State: ______________ Zip: __________ Home Phone: ( ) __________

Employer: ______________ Address: ______________

City/State: ______________ Zip: __________ Work Phone: ( ) __________

INSURANCE INFORMATION (Primary) (PLEASE PROVIDE INSURANCE CARD FOR US TO COPY.)

Insurance Co.: ______________ Address: ______________

City/State: ______________ Zip: __________ Insurance Co. Phone: ( ) __________

Policy Holder: ______________ Date of Birth: __________

ID/Policy #: __________ Group #: __________ Group Name: __________

INSURANCE INFORMATION (Secondary)

Insurance Co.: ______________ Address: ______________

City/State: ______________ Zip: __________ Insurance Co. Phone: ( ) __________

Policy Holder: ______________ Date of Birth: __________

ID/Policy #: __________ Group #: __________ Group Name: __________

To the best of my knowledge, all of the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. **(PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMENT.) IN ORDER TO MONITOR YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.** Thank you.

If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

PATIENT SIGNATURE: ______________ DATE: ______________

MEDICARE ASSIGNMENT/SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Allied Hematology Oncology Associates for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services, formerly the Health Care Administration, and its agents, any information needed to determine these benefits, or the benefits payable for related services.