

PATIENT INFORMATION

NEW

OFFICE UPDATE

Last Name _____

First Name _____ MI _____

Street Address _____

PO Box _____

City _____

State _____ Zip Code _____

SEX: M F

Employed Yes No Student Retired

Employer _____

Work Phone # _____

Home Phone # _____

Cell # _____

Date of Birth _____

Social Security # _____

Marital Status: S M W D Name of Spouse _____ Spouse's Day Phone # _____

Emergency Contact (Other than spouse) _____ Day Phone # _____

Relationship: _____

Patient Email Address: _____

Name of Primary Care Physician _____

PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT):

Last Name _____ First Name _____ MI _____

Address (if other than patient) _____

INSURANCE INFORMATION

PLEASE HAVE RECEPTION TAKE A COPY OF YOUR CARD(S): INSURANCE CARDS COPIED NO INSURANCE

If your insurance is under your spouse's name or other family member, you MUST supply a Social Security Number and a Date of Birth for the card holder.

CARDHOLDER (NAME OF SUBSCRIBER)

RELATIONSHIP TO PATIENT

DOB OF SUBSCRIBER

SSN OF SUBSCRIBER

EMPLOYER OF SUBSCRIBER

EFFECTIVE DATE OF COVERAGE

I accept responsibility for payment in full of my medical services and hereby authorize all Insurance benefits to be paid directly to Frontier Cancer Center and Blood Institute. I also authorize release of medical Information necessary to process Insurance claims.

****SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE

WRITTEN ACKNOWLEDGMENT

I acknowledge that I have received a copy of Frontier Cancer Center and Blood Institute's Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

****SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

WITNESS

DATE

DATE

PATIENT COMMUNICATION REQUEST

To respect your privacy, please tell us how you would like us to communicate with you regarding your healthcare, e.g., test results, appointment changes, surgery schedule, etc.:

If you are not there to take our call, do you want us to leave a message?

Home: YES NO
Work: YES NO
Cell: YES NO

**** Are there family members or friends to whom we may disclose your health care information?

YES NO

If yes, please list their relationship, names and phone numbers, if known:

NAME _____ RELATIONSHIP _____ PHONE: MAY WE LEAVE A MESSAGE? YES NO

NAME _____ RELATIONSHIP _____ PHONE: MAY WE LEAVE A MESSAGE? YES NO

NAME _____ RELATIONSHIP _____ PHONE: MAY WE LEAVE A MESSAGE? YES NO

NAME _____ RELATIONSHIP _____ PHONE: MAY WE LEAVE A MESSAGE? YES NO

RELEASE OF INFORMATION TO OTHERS

By signing this form, I understand that I am authorizing Frontier Cancer Center and Blood Institute to disclose health care information to the person(s) listed above, that I can revoke this authorization in writing, and doing so will stop future use or disclosure of this information. I understand you will act on this authorization until I revoke that authority.

****SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE