Hematology & Oncology Consultants of Pennsylvania, P.C.

Patient Information

PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

Name: _____ Phone: (_____)_____
Last First M.I. Maiden Name *Home*

(_____)_____
Address: _____ *Work*

(_____)_____
_____ *Cell*
City State Zip

*e-mail:*_____

Date of Birth*:* _____/_____/_____

Social Security Number: _____

Marital Status: □ Married □ Divorced Sex: □ Male □ Female
□ Single □ Widowed

Employer: _____
Company name *Phone*

Are you a resident of an assisted care or rehab facility? _____
(Name) (Phone)

Spouse

Name: _____
Last first middle initial

Date of birth:_____/_____/_____ Phone: ( )_____

Social Security Number: _____

Address (if different than above):_____
Street City State Zip

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____
Signature *Date*

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims and/or to Physicians involved in my care, not limited to Physicians listed below.

_____
Primary Care/Family Physician

_____ _____
Referring Physician *Signature* *Date*

**********MEDICARE SUBSCRIBERS**********

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below.

Hematology & Oncology Consultants of Pennsylvania,, P.C.
101 Erford Road, Suite 101

_____
Signature *Date*