Carolina BioOncology Institute, PLLC

PATIENT INFORMATION

Please answer all questions. Answers are also used in participating with Federal compliance initiatives.

Date _____ Name _____
Last Middle/Maiden First

Preferred Name_____ Preferred Language _____

Address _____
Street County

_____
City State Zip Code Country

DOB_____/_____/_____ SS #_____ Email_____

Home Phone _____ Cell Phone _____ Work Phone_____

CIRCLE ANSWER: Male / Female Marital Status: Married / Separated / Divorced / Single / Life Partner / Widowed

Race: African American / American Indian / Caucasian / East Indian / Hispanic / Asian / Pacific Islander/
(other):_____

Ethnicity: Caucasian /African Am / Chinese / Hispanic / Indian / Japanese / Korean / Arab / Irish / (other):_____

Employed / Unemployed / Retired (as of year)_____ / Disabled (as of year) _____

Employer _____ Occupation _____

Primary Care Physician _____ Phone _____

How did you hear about us? Physician Referral / Hospital / Web Site / Yellow Pages / Multidisciplinary Clinic / Patient / Radio
(other):_____

Are you in a Skilled Nursing Facility? Yes / No If yes, name & number of facility: _____

Emergency Contact Name _____ Relationship_____ Phone _____

How may we contact you? (circle all that apply) email / home phone / work phone / cell phone

Preferred Pharmacy _____ Location _____ Phone _____

INSURANCE INFORMATION—Please give receptionist ALL medical insurance cards that you are covered under.

Primary Insurance _____

Policy Holder Name _____
If other than patient

Relationship to Patient _____
Date of Birth of Policy Holder _____
SS# of Policy Holder _____

Secondary Insurance _____

Policy Holder Name _____
If other than patient

Relationship to Patient _____
Date of Birth of Policy Holder _____
SS# of Policy Holder _____

I hereby authorize Carolina BioOncology Institute, PLLC, to release information acquired in the course of my treatment to my insurance carrier(s), Medicare, attorneys, or agencies involved in the payment of my account as well as any physicians assisting in my care. I hereby assign payment directly to Carolina BioOncology Institute, PLLC, for medical expenses rendered to myself or my dependents. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I understand that this consent will remain in effect until revoked, in writing, by myself.

Patient Signature _____ Date _____
Name & Relationship (if other than patient) _____
Please provide documentation to support Power of Attorney, Healthcare Representative, etc. *Rev. 6/2011, 9/2011, 10/2011*