# Patient / Responsible Party Information

Patient Name:______________________________________________________________
(First) (Middle) (Last)

Date of Birth:_______________________ Age:_______ Sex:_____ Social Security No.___________________

Marital Status (circle one): Single Married Widowed Separated Divorced

Mailing Address:____________________________________________________________

City:______________________________________State:__________Zip:________________

Physical Address (if different from mailing):__________________________________________

City:_________________________________________State:__________Zip:______________

Home Phone:________________________Cell:________________________Work:_____________________

Which number do you prefer we use to contact you?______________________________________

Email Address:______________________________________________@_________________________

Race: White☐ Black/African American☐ Asian☐ American Indian or Alaska Native☐
Native Hawaiian or Other Pacific Islander☐

Ethnicity: Hispanic or Latino☐ Non-Hispanic or Latino☐ Decline to Answer☐

Primary language spoken at home:_____________________________ Are you a Veteran? ☐Yes ☐No

Employer:__________________________________________Occupation:___________________________

Spouse's Name:____________________________________DOB:______________SSN:____________________

Spouse's Employer:____________________________________ Spouse's Phone:_____________________
Do you give us permission to send your personal medical record to your secure Patient Portal? ☐Yes ☐No

Responsible Party (if other than patient):

Name:____________________________________DOB:____________Relationship to Patient:______________

Address:__________________________________________City:_______________ST:______Zip:____________
_
Home Phone:__________________________Cell:______________________________Work:_________________

Emergency Contact – Please list the closest friend or relative not living with you.

Name:_____________________________________________Relationship:_____________________________

Address:__________________________________________City:_______________ST:______Zip:____________

Home Phone:__________________________Cell:______________________________Work:_________________

Referred By:______________________________________________________Phone:______________________

Primary Care Physician:__________________________________________Phone:______________________

Primary Insurance Information

Company:________________________________________________Phone:____________________________

Policy Holder:______________________________________DOB:____________Relation:________________

Policy/Member Number:_________________________________ Group Number:__________________________

Secondary Insurance Information

Company:________________________________________________Phone:____________________________

Policy Holder:______________________________________DOB:____________Relation:________________

Policy/Member Number:_________________________________ Group Number:__________________________

To the best of my knowledge, all of this information is true and correct. 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 what 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.)

I grant permission to my physician to mutually exchange medical information with my referring physician(s) and/or their associates. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record to my insurance and Medi-gap carriers. 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 cost of collection. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to me or my dependent. 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.

Signature:________________________________________________________Date:______________________

Spouse's Signature(if applicable):_______________________________________Date:______________________

ASSIGNMENT/SIGNATURE ON FILE:

I request that payment of authorized Medicare, Medicaid, and/or other insurance benefits be made directly to HIGHLANDS ONCOLOGY GROUP for any service provided to me by HIGHLANDS ONCOLOGY GROUP. I authorize HIGHLAND ONCOLOGY GROUP to release information to HCFA and its agents any information needed to determine benefits.

Signature:________________________________________________________Date:______________________