ALLIANCE
Cancer Specialists

PATIENT INFORMATION

Patients Name_____ **Date of Birth**_____
Social Security Number_____
Street Address_____ **Home Phone**_____
City_____**State**____ **Zip** _____ **Cell Phone**_____

Emergency Contact & Relationship to Patient_____ **Phone Number**_____
Marital Status: Single Married Widowed Divorced Separated
Patient Employer_____**Phone Number**_____
Family Physician_____ **Phone Number**_____
Referring Physician_____**Phone Number**_____
Pharmacy _____ **Pharmacy Phone Number**_____
Pharmacy Address_____

INSURANCE INFORMATION

Primary Insurance
Subscriber Name:_____ **Date of Birth**_____
Relationship to Patient;_____ **Social Security #**_____
Subscriber Employer:_____ **Phone #**_____
Address:_____
Effective Date:_____

Secondary Insurance
Subscriber Name:_____ **Date of Birth**_____
Relationship to Patient;_____ **Social Security #**_____
Subscriber Employer:_____ **Phone #**_____
Address:_____

Additional Insurance
Subscriber Name:_____ **Date of Birth**_____
Relationship to Patient;_____ **Social Security #**_____
Subscriber Employer:_____ **Phone #**_____
Address:_____
Effective Date:_____

Authorization

- **I authorize any holder of medical or other information about me to release this information to any insurance company, its intermediaries or carriers or another physician's office**
- **I hereby authorize direct payment of medical benefits to include major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to Bux-Mont Oncology Hematology Medical Associates, PC.**
- **I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.**
- **I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all personal balances.**

Signature of Patient or Responsible Party_____ **Date**_____
DO YOU HAVE A LIVING WILL? Yes No

(FOR OFFICE USE ONLY: Date entered:_____ Entered by:_____)