



PATIENT INFORMATION

Patients Name, Social Security Number, Street Address, City, State, Zip, Date of Birth, Home Phone, Cell Phone, Emergency Contact & Relationship to Patient, Marital Status, Patient Employer, Family Physician, Referring Physician, Pharmacy, 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:)