ALLIANCE
Cancer Specialists

PATIENT INFORMATION

Patient's Name_____Date of Birth_____ Sex: M F Other

Social Security Number_____E-Mail_____

Street Address_____ Home Phone_____

City_____ State_____ Zip_____ Cell Phone_____

Emergency Contact_____ Relationship to Patient_____

Emergency Contact Phone Number_____

Primary Care Physician_____ Phone Number_____

Referring Physician_____ Phone Number_____

INSURANCE INFORMATION

Primary Insurance_____ ID# _____

Subscriber Name_____ Date of Birth_____

Relationship to Patient_____ Effective Date _____

Subscriber Employer _____ Phone #_____

Employer Address_____

Secondary Insurance_____ ID# _____

Subscriber Name_____ Date of Birth_____

Relationship to Patient_____ Effective Date _____

Subscriber Employer _____ Phone #_____

Employer Address_____

If you are under 65 and have Medicare, please explain: _____

If you are over 65 and do not have Medicare, please explain: _____

Pharmacy Insurance _____ ID# _____ Phone# _____

- 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 Alliance Cancer Specialists, P.C.
- 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**_____