ALLIANCE
Cancer Specialists

Patient Information

Please complete the information below to the best of your ability.

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 _____

Pharmacy Insurance _____ ID# _____ Phone# _____

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 <u>do not</u> have Medicare, please explain: _____

• 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**_____