WELCOME TO OUR OFFICE **Hematology Oncology Associates of W. Suffolk, PC**

In order to serve you properly we will need the following information. Please PRINT all information. Thank you.

Patient's name	___ Male ___ Female	Birthdate	Marital status ___ Single Married ___ ___Widowed Divorced ___	Social Security #

Residence Address:	City:	State	Zip	Home #

Email Address:	Any known allergies? ___Yes ___No Please list them	Cell #

Name of employer	Town located	Business phone	Occupation

Name of primary care physician	Address (City, State, Zip)	Phone
Referring physician's name (if different)	Address (City, State, Zip)	Phone

Do you have medical insurance? ___Yes (please fill out info below) ___ No	How do you intend to pay? ___ Check ___ Cash ___ Credit card

Primary insurance company name and address	Policy number	Group number	Referrals required?

Name of subscriber (who's insurance is it?)	Relationship to patient ___ Self ___ Spouse ___ Parent (name) ___ Other (explain who)

Name of spouse (or parent if patient is child)	Address if different from patient	Spouse's birthdate	Spouse's Social Security #
Spouse's employer (or parent if patient is child)	Town located	Business phone	Occupation

Do you have another insurance carrier? __Yes (please fill out info below) __No	Is this insurance through an employer or previous employer? ___Yes ___No Employer's Name:

Insurance company name and address	Policy number	Group number	Referrals required?

Name of subscriber (who's insurance is it?)	Relationship to patient ___ Self ___ Spouse ___ Parent (name) ___Other (explain who)	Do you have a third insurance carrier? ___Yes ___No

Name of nearest friend or relative for emergency contact not listed above	Relationship to patient	Phone #

Do you have a prescription plan? ___Yes ___No Do you have a mail-away plan for a 3-month supply of medication? ___Yes ___No	Local pharmacy name and phone number:

I request that payment by my insurance carrier _________________________________ (name) be made directly to the doctors at Hematology Oncology Associates for service(s) described. I accept full responsibility for the unpaid portion of the bill (20% and deductible for Medicare). Hematology Oncology Associates reserves the right to collect all unpaid balances. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing administration or their intermediats or carriers, or to the billing agent of this physician, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I also authorize my medical records at another physician/facility be released to the above practice upon request.

Signed ____Date____________________________________