Carolina BioOncology Institute, PLLC

PATIENT INFORMATION

Please answer all questions. Answers are also used in our efforts for cancer research and will aid us immensely.

Date ____________________ Preferred Name ____________________

Name ______________________________ Male/Female Race ____________
Last Middle/Maiden First

Address ____
Street County

____
City State Zip Code Country

DOB __________ SS # __________ Email ____________________

Home Phone ______________ Cell Phone ______________ Marital Status __________

Circle one- Employed / Unemployed Retired? (date) ________ ______ Disabled? (date) __________

Employer ______________ Occupation ______________ Work Phone ______________

Employer Address ______________________________ Date of Hire ______________

Primary Care Physician ______________________________ Phone ______________

Referred _______yes __________no Source (yellow pages, yellow book, physician, friend, etc?): ______________

Are you in a Skilled Nursing Facility? yes / no If yes, name & number of facility: ______________

Emergency Contact Name ____________________ Relationship ____________________

Phone ______________________________ Alternate Phone ____________________

Preferred method of contact: (circle all that apply) email home phone work phone cell phone

Pharmacy ______________ Location ______________ Phone ______________

INSURANCE ---Please give receptionist ALL medical insurance cards

Primary Insurance: ____________________ Secondary Insurance: ____________________

Policy Holder Name: ____________________ Policy Holder Name: ____________________

Relationship: ____________________ Relationship: ____________________

I hereby authorize Carolina BioOncology Institute, PLLC, to release information acquired in the course of my treatment to insurance carriers, Medicare, attorneys, or agencies involved in the payment of my account as well as any physicians assisting in my care. I hereby assign payment directly to Carolina BioOncology Institute, PLLC, for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I understand that this consent will remain in effect as long as I or my dependent remains a patient or until revoked, in writing, by myself.

Patient Signature ______________________________ Date ______________

Relationship (if other than patient) ______________________________