CAROLINA ONCOLOGY ASSOCIATES, P.A.

Last Name: _____ First Name: _____ Mid. Intl: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Age:_____ Date of Birth _____ Gender _____ Social Security #: _____

Ethnicity:_____ Marital Status: _____ Spouse's Full Name: _____

Your Occupation: _____ Employer's Name: _____

Employer's Address and Phone: _____

Emergency Contact: Name _____ Phone _____ Relationship _____

Which physician referred you to this practice? (Name)_____ _____

Who is your primary care physician: (Name) _____

Any other doctors treating you at this time: _____

What is your preferred pharmacy: _____ **Mail Order Pharmacy:** _____

Do you have a Living Will?_____ **Do you have a Power of Attorney?**_____ **If yes, who?**_____

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Primary Insurance Carrier:

Name: _____

Policy Holder Relationship to You: _____

Policy Holder Name: _____

Date of Birth: _____ Gender: _____

Policy ID# _____ Group # _____

Secondary Insurance Carrier

Name: _____

Policy Holder Relationship to You: _____

Policy Holder Name: _____

Date of Birth: _____ Gender: _____

Policy ID# _____ Group # _____

Do you have a cancer policy? (Circle One) YES NO

I understand that unless other arrangements are made in advance or where applicable federal or state laws supersede, all fees are the responsibility of the patient and are due at the time of service.

I authorize release of any medical or other information necessary to process medical claims for professional services rendered by this office and its health care providers.

I authorize the release of any of my medical information to any of my other doctors to ensure quality care, as well as those individuals I have listed above as authorized to have access to my medical information.

Patient Signature: _____ **Date:** _____