

# meridian park radiation oncology center

Date \_\_\_\_\_ Diag. \_\_\_\_\_ Dr. \_\_\_\_\_ Referred by \_\_\_\_\_ Acct# \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Other Physicians** \_\_\_\_\_ **Other Physicians** \_\_\_\_\_

## Patient Information

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Phone No.: Home \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

**ADVANCED DIRECTIVES?**  YES  NO **WHERE FILED?** \_\_\_\_\_

## Spouse / Significant Other Information

Name \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City State Zip

Date of Birth \_\_\_\_\_ Spouse Social Security # \_\_\_\_\_

## Additional Contact

Nearest Friend or Relative Not Living with You. (Someone other than Spouse)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## How did you hear about us? (check all that apply)

Newspaper  Magazine  TV  Referred by another Doctor  Friend  Billboard  Other \_\_\_\_\_

## Insurance Information

**Prior Authorization Needed:**  Yes  No **Co Pay:**  Yes  No \$ \_\_\_\_\_

**Policy Holder Info:**  Patient  Spouse  Employer  Other \_\_\_\_\_

Primary Ins: \_\_\_\_\_ I.D. No. \_\_\_\_\_

Address \_\_\_\_\_ Policy or Group No. \_\_\_\_\_

**Policy Holder Info:**  Patient  Spouse  Employer  Other \_\_\_\_\_

Secondary Ins. \_\_\_\_\_ I.D. No. \_\_\_\_\_

Address \_\_\_\_\_ Policy or Group No. \_\_\_\_\_

### ASSIGNMENT OF INSURANCE BENEFITS

I hereby agree to full responsibility for all expenses incurred by or on account of this patient, and hereby assign to Meridian Park Radiation Oncology Center any and all insurance benefits due to me to the full extent of my financial obligation to said clinic.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Insured or Authorized Person

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Meridian Park Radiation Oncology Center to release to my insurance co. any acquired in the course of my examination or treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Patient (Parent or Guardian if Minor)

**A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL**