NORTHWEST ONCOLOGY, P.C.

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PATIENT INFORMATION

Patient Name _____ ☐ Male ☐ Female
Last First Middle

Date of Birth _____ Age _____ Social Security _____ - _____ - _____

Address _____

Telephone (_____) _____ Cell Phone (_____) _____

Email Address: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse Name _____

Patient's Employer _____ Phone (____) _____ ☐ Retired ☐ Active

Preferred Language _____

Race (Please circle one.)

American Indian or Alaska Native
Asian
Black or African American
Unreported/Refuse to report
Caucasian
Latino
Other

Ethnicity (Please circle one.)

Hispanic or Latino
Non-Hispanic or Latino
Unknown

Nearest Relative (Not living with you) Name _____

Relationship _____ Telephone ___(_____)_____

Family Doctor (primary care) _____

Physician who referred you _____

Email Address: _____

Would you like to sign up for our patient portal? ☐ Ask the front desk for more information.

Patient name: _____ Date: _____

PRIMARY INSURANCE

Insurance _____

Name of Insured _____

SS# _____

ID# _____ GRP# _____

Insured's Employer _____

Insurance Customer Ph# _____

SECONDARY INSURANCE

Insurance _____

Name of Insured _____

SS# _____

ID# _____

Insured's Date of Birth _____

Insured's Employer

PHARMACY

Pharmacy Name _____ ID# _____

Telephone _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

Name of Insured: _____

I request that payment of authorized Medicare benefits and all Non-Medicare benefits be made either rot me or on my behalf for services furnished me by Northwest Oncology, P.C., including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its agents, and all other respective agents' information needed to determine these benefits or any benefits for related services. I understand that I am financially responsible to Northwest Oncology, P.C., for services not covered by my insurance policies.

_____

Signature Insured/Representative/Legal Guardian Date

You will be provided our HIPAA privacy policy at the time of your appointment and will be sked to sign below at that time. I have received, read and understand the Notice of Privacy Practices.

_____

Signature Insured/Representative/Legal Guardian Date