REGIONAL
MEDICAL ONCOLOGY CENTER

Patient Demographics

Name: ____ **Gender:** ☐ Male ☐ Female
First *Middle* *Last*

Address: ______________________________ **City:** ____________ **State:** _____ **Zip:** _______

Home Phone: ____________ **Cell:** ____________ **Work:** ____________ **Preferred:** ☐Home ☐Cell ☐Work

Email: ______________________ **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Birth: __________ **Social Security #:** ____________ **Language:** ☐ English ☐ Spanish ☐ Other: ________

Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino **Race:** ☐ African American ☐ Caucasian ☐ Asian ☐ Hispanic ☐ Other

Advanced Directives:

Living Will ☐ Yes ☐ No **Durable Power of Attorney** ☐ Yes ☐ No **DNR** ☐ Yes ☐ No

Emergency Contact:

Name: ____________________ **Relationship:** ______________ **Phone Number:** ______________

Medical Care Providers:

Referring Provider: ______________________ **Primary Care Provider:** ______________________

Insurance Information:

Primary Insurance: ________________ **Policy ID #:** ______________ **Insurance Group #:** __________

Secondary Insurance: ________________ **Policy ID #:** ______________ **Insurance Group #:** __________

PLEASE COMPLETE THE FOLLOWING IF INSURED PERSON IS DIFFERENT THAN THE PATIENT

Relationship to Patient: ☐ Spouse ☐ Other: ____________

Insured Name: ____
First *Middle* *Last*

Date of Birth: __________ **Social Security #:** ____________

I request that direct payment of authorized Medicare and/or commercial insurance benefits be made to Regional Medical Oncology Center, and the deductible and copayment balances will be paid by the patient and/or guarantor. I further authorize the release of medical information to my physician(s) or my insurance companies that may be pertinent to my care.

______________________________________ ________________

Signature **Date**