# CHESAPEAKE ONCOLOGY - HEMATOLOGY ASSOCIATES, P.A.

## *NEW PATIENT REGISTRATION FORM*

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| Today's date: | ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. | Last name: | First: | Middle: |
| Gender: ☐ M ☐ F | Age: | Birth date (mm/dd/yyyy): | | |
| Social Security Number: | | Home phone: | | Cell phone: |
| Home address: | | City: | State: | Zip: |
| Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | | | | |
| Referred by (please check one box):<br>☐ Primary Care Physician<br>☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend<br>☐ Close to home/work ☐ Yellow Pages ☐ Other _____ | | | | |
| Primary Care Physician (PCP): | Office Address: | Office Phone/Fax: | | |
| Referring Physician: | Office Address: | Office Phone/Fax: | | |

| INSURANCE INFORMATION | | |
|---|---|---|
| (Please give your insurance card to the receptionist.) | | |
| Is this patient covered by insurance? ☐ Yes ☐ No | | |
| Person responsible for bill: | | |
| Address (if different): | | |
| Home phone no.: | | |
| Occupation: | | |
| Employer: | Employer Address: | Employer phone no.: |
| Please indicate **primary** insurance: | | |
| Group no.: | Policy no.: | Co-payment: $ |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date (mm/dd/yyyy): |
| Patient's relationship to subscriber:<br>☐Self ☐Spouse ☐Child ☐Other | | |
| Please indicate **secondary** insurance (if applicable): | | |
| Group no.: | Policy no.: | Co-payment: $ |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date (mm/dd/yyyy): |
| Patient's relationship to subscriber:<br>☐Self ☐Spouse ☐Child ☐Other | | |

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## *NEW PATIENT REGISTRATION FORM*

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| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| **Name of friend or relative:** | **Relationship to patient:** | **Home phone no.:** | **Work phone no.:** |
| *Living at same address*<br>1. | | | |
| *Not living at same address*<br>2. | | | |
| *Not living at same address*<br>3. | | | |

**BILLING AND MEDICAL INFORMATION AUTHORIZATION**

If you would like to authorize someone to receive your billing and medical information, please complete the section below.

| **Name:** | **Phone number:** | **Relationship:** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

As a courtesy, we may contact you regarding, but not limited to, upcoming appointments or lab results.
What is your preferred method of contact?

| | |
|---|---|
| At home : | At work: |
| Leave message on machine: ☐ Yes ☐ No | Leave message on voicemail: ☐ Yes ☐ No |
| Leave message with person: ☐ Yes ☐ No | Leave message with person: ☐ Yes ☐ No |
| Other: | Other: |

**PATIENT/GUARDIAN SIGNATURE**

**The information listed on this sheet is true to the best of my knowledge. I understand that I am responsible for any referrals needed for my care. I understand that I am financially responsible for any balance. I authorize my insurance benefits be paid directly to the physician. I also authorize Chesapeake Oncology - Hematology Associates, P.A. or insurance company to release any information required to process my claims.**

| **Patient/Guardian signature:** | **Date:** |
|---|---|
| | |