DOTHAN Hematology + Oncology

PATIENT INFORMATION

Please Complete Entire Form

Today's Date: _____ /_____ /_____ Doctor You Are Seeing Today: ❑ Dunn ❑ McAllister ❑ Blackmon

Referring Doctor: _____ Primary Care Physician:_____

Patient's Name: _____
First MI Last

Date of Birth: _____ /_____ /_____ Sex: ❑ Male ❑ Female Marital Status:_____

Race: ❑ African American ❑ Caucasian ❑ Asian ❑ Latin ❑ American Indian ❑ Pacific Islander ❑ Other

SS#: _____–_____–_____ Preferred Language: _____ Ethnicity: _____

Advance Directives: ❑ Living Will: YES NO ❑ Durable Power of Attorney: YES NO ❑ DNR: YES NO

Address: _____ City: _____ State _____ Zip:_____

Home Phone: _____ Cell#: _____ E-mail Address: _____

Preferred Method of Contact: ❑ Mail ❑ Home Phone ❑ Cell Phone

Employer:_____ Address:_____ Phone #:_____

Emergency Contact: _____ Phone #: _____ Cell#: _____
Someone that does not live in your home

Spouse/Guardian Name: _____ Relationship: _____

Address: _____ City: _____ State _____ Zip:_____

Phone #:_____ Cell#:_____ Employer: _____

Preferred Pharmacy: _____ Pharmacy Location and Phone #: _____

Primary Insurance Plan:_____
Policy #: _____
Name of Insured: _____
DOB: _____ SSN: _____-_____-_____

Secondary Insurance Plan_____
Policy #: _____
Name of Insured: _____
DOB: _____ SSN: _____-_____-_____

Present Insurance Cards and ID (Divers License Preferred) Upon Completion of This Form

Is Prior Authorization Required? Office: ❑ Yes ❑ No Hospital: ❑ Yes ❑ No

Are you enrolled in a Hospice program? ❑ Yes ❑ No If yes, name of Hospice _____

Insurance Authorization and Assignment of Benefits:

I hereby authorize Dothan Hematology and Oncology to mail or fax any medical information necessary to process insurance claims. I authorize payment of medical benefits to the above provider for professional services rendered. I authorize the use of this signature on all insurance submissions made on my behalf.

Patient Signature: _____ Date: _____