4004 Pioneer Woods Drive Lincoln, NE 68506
YourCancerCare.com

Phone: 402.484.4900
Fax: 402.484.6456

PATIENT INFORMATION DATA SHEET

ALL INFORMATION IS ESSENTIAL – PLEASE DO NOT LEAVE ANY FIELDS BLANK

First: ____________________ MI:___ Last Name: ______________________ DOB: ___ /___ /___ SSN: _____-____ - _____

Email Address: ____ Gender: M / F Marital Status ___________

For lab results and important information

Address: ____ City: _________________________ State: ________ Zip: ________________

Phone Numbers: Home: ____________________ Work: ____________________ Cell: ____________________

Preferred Method of Contact: Home___ Work___ Cell ___ **May we leave a message regarding appointment information? Y / N**

Preferred Language: ____________________________________

Ethnicity: Are you of Hispanic or Latino origin? **Y / N** ☐ Declined or Unknown Race___________________ ☐ Declined

Your Employer: ____ If Retired, Date of Retirement: __________________________

Primary Care Physician: ____ Referring Physician: ______________________________________

CONTACT NAME	PLEASE INDICATE DESIRED AUTHORIZATION* Release of Records (i.e. Appt/medical care)	Emergency Contact	PHONE	RELATIONSHIP TYPE
____________________________	☐	☐	____________________	**Spouse Child Other____**
____________________________	☐	☐	____________________	**Spouse Child Other____**
____________________________	☐	☐	____________________	**Spouse Child Other____**

*This authorization shall be effective until I (the patient) revoke this authorization: All past, present, and future periods.

NOTE: You may revoke this authorization at any time by notifying NHO in writing.

HEALTH INSURANCE INFORMATION

Please provide us with your insurance card so we can make copies for your chart.

	Insurance Carrier	Subscriber Name	Subscriber SS#	Subscriber DOB	ID	Relationship to Subscriber
Primary:	__________________	____________________	_____ / ____ / _____	____ / ____ / ___	______________	Self / Spouse / Child / Other
Secondary:	__________________	____________________	_____ / ____ / _____	____ / ____ / ___	______________	Self / Spouse / Child / Other
Tertiary:	__________________	____________________	_____ / ____ / _____	____ / ____ / ___	______________	Self / Spouse / Child / Other
Prescription*:	__________________	____________________	_____ / ____ / _____	____ / ____ / ___	______________	Self / Spouse / Child / Other

***Is your prescription coverage any of the following:** Medicare Part D______ Group/Individual Plan______ VA only______

ATTN: Medicare Patients: If you are covered with Group Insurance thru an employer that you or your spouse are NOW RETIRED FROM, then list Medicare as Primary and the Group Plan as Secondary. If you're employed full-time, then the group plan would be Primary and Medicare would be Secondary.

I realize that the responsibility for all medical expenses is mine and any dispute with the insurance company is not reason for nonpayment of this account. My signature below will authorize the release of any medical or other information necessary to process my claims. I also authorize all payment of medical benefits to Nebraska Hematology-Oncology, P.C. for all claims on my behalf.

Signature: ____ Today's Date: ________________________________

It is mutually agreed that a photographic copy of this signature shall be as valid as the original.

FOR OFFICE USE ONLY:
Reviewed by: ___________
Updated by: ___________