4004 Pioneer Woods Drive Lincoln, NE 68506 Phone: 402.484.4900
YourCancerCare.com Fax: 402.484.6456

PATIENT INFORMATION DATA SHEET Today's Date: ________________

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

Name: ______________________________________ DOB: ____/___ /_____ SS#: _______ – ______ – _________

Gender: **M / F** **Email Address:** ______________________________ Marital Status: ____________
Please print: (*Email needed for test results and important information)*

What is your Preferred Language: ______________________________
What is your Race: _______________________________ ☐ Declined
What is your Ethnicity: Are you of Hispanic or Latino origin? ☐ Yes ☐ No ☐ Declined or Unknown

Address: ______________________________ City: ________________ State: ______ Zip: __________

Phone Numbers: Home: [ ] _____________ Work: [ ] _____________ Cell: [ ] _____________

May we leave a message regarding appointment information? Y / N

Preferred Method of Contact: [ ]**Home Phone** [ ]**Cell Phone** [ ]**Work Phone**

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

Primary Care Physician: ___________________________ Referring Physician: ___________________________

EMERGENCY CONTACT	Phone	Relationship	**OK to release information to?**
____________________________	( ) ______________	**Spouse Child Other**_______	**Y / N**
____________________________	( ) ______________	**Child Other** __________	**Y / N**
____________________________	( ) ______________	**Child Other** __________	**Y / N**

HEALTH INSURANCE INFORMATION

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

	Employee Name	**SS#**	**DOB**	**Employer**	**Relationship**
Primary: ____________	______________	___ / ___ / ____	___ / ___ / ___	____________	Self Spouse / Parent
Secondary: ____________	______________	___ / ___ / ____	___ / ___ / ___	____________	Self Spouse / Parent
Tertiary: ____________	______________	___ / ___ / ____	___ / ___ / ___	____________	Self Spouse / Parent

ATTN: Medicare Patients: If you are covered with Group Insurance through 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.

****Do you have Prescription Coverage: Y/N: Please provide us with a copy of your prescription insurance card.**
Is it: _______ Medicare Part D or _______ Group or Individual Plan or _______ VA only or _______None

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

REQUIRED QUESTIONS TO BE ANSWERED BY ALL MEDICARE PATIENTS

ARE YOU A VETERAN?	Y / N	IS THIS MEDICAL CONDITION DUE TO AN ACCIDENT OF ANY KIND?	Y / N
DID THE VA REFER YOU HERE FOR TREATMENT?	Y / N	IF YES, WAS IT RELATED TO: ☐WORK ☐AUTO ☐HOME ☐OTHER	
DO YOU HAVE A VA FEE BASIS ID CARD?	Y / N	ARE YOU COVERED BY AN EMPLOYER'S HEALTH INSURANCE PLAN	
DO YOU HAVE A FEDERAL BLACK LUNG CARD?	Y / N	THROUGH YOUR OWN EMPLOYMENT OR THAT OF A FAMILY MEMBER (NOT RETIREE COVERAGE)?	Y / N