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YourCancerCare.com

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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: _____

RELEASE OF INFORMATION

	Phone	Relationship Type
_____	() _____	Emergency Contact
_____	() _____	Spouse Child Other _____
_____	() _____	Spouse Child Other _____
_____	() _____	Spouse Child Other _____

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: _____