HEMATOLOGY / ONCOLOGY CLINIC

Consult with (check one)

_____ Gerald P. Miletello, M.D.	_____ Georgia A. Reine, M.D.
_____ Deborah A. Abernathy, M.D.	_____ Christopher M. McCanless, M.D.
_____ Michael J. Castine III, M.D.	_____ Vince D. Cataldo, M.D.

PATIENT INFORMATION (PLEASE PRINT)

Name ____ **Home Phone** ___________________

Social Security # __ __ __ - __ __ - __ __ __ __ **Date of Birth** __ __ / __ __ / __ __

Home Address ____

City _____________________________________ **State** _________________ **Zip** ___________

Work Phone _________________ **Cell Phone** _________________ **Marital Status** __________

Referring Physician __________________________________ **Phone** ____________________

Emergency Contact ________________________________ **Phone** _____________________

SPOUSE INFORMATION (PLEASE PRINT)

Name ___________________________ **Work #** _________________ **Cell #** ________________

INSURANCE INFORMATION (PLEASE PRINT)

Primary Insurance _______________________ **Group#** __________ **ID#** ___________________

Second Insurance ________________________ **Group#** __________ **ID#** ___________________

Spouse's Social Security # __ __ __ - __ __ - __ __ __ __ **Date of Birth** __ __ / __ __ / __ __

Married_____ **Single**_____ **Other**______

AUTHORIZATION / RESPONSIBILITY

ASSIGNMENT OF BENEFITS:
I request that payment of authorized Medicare / Private Insurance benefits be made either to me or on my behalf to Hematology / Oncology Clinic for any services furnished me by that provider.
I authorize any holder of medical information about me to release to the Health Care Financing Administration / Private Insurance and its agents any information needed to determine these benefits for the benefits payable for related services.

____ _______________________
Signature of Patient or Authorized Representative **Date**

Hematology / Oncology Clinic
A copy can be considered as an Original for Insurance Purposes.
I Acknowledge and Understand that I am Responsible for any Professional Services Rendered to me. Although I have requested the Doctor to Bill my Insurance Company, I Clearly understand that it is my responsibility to make sure my Bill is paid in a reasonable amount of time. If for any reason my Bill is not paid in full by my insurance, I further Agree to make arrangements to settle the unpaid balance on my account.

____ _______________________
Signature of Patient or Authorized Representative **Date**