

Patient # (office use only) _____

Date: _____

Charleston Hematology Oncology Associates, PA
Demographics

PLEASE PRINT AND COMPLETE

Patient's Name: _____
First Middle Last

☐ Single ☐ Widow
☐ Married ☐ Divorced

Social Security No: _____ Race: _____ Sex: M F Marital Status: _____

Ethnicity: Hispanic yes no non-specified Are you in a skilled nursing facility? yes no

Address: _____
No/Apt. Street City State Zip

Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Email Address: _____

Patient's Employer: _____
name & address of company

Spouse's Name: _____ Date of Birth: _____

Spouse's Social Security No: _____ Work Phone: _____

Spouse's Employer: _____

Person Responsible if other than patient: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred by: _____ Primary Care Physician: _____

Primary Insurance Information: _____
Name of Insured

Insurance Company Name

ID Number

Group No.

Secondary Insurance Information: _____
Name of Insured

Insurance Company Name

ID Number

Group No.

By signing this consent, you:

- accept personal responsibility for all services rendered to you. If your insurance company does not pay for the service(s) rendered, you accept personal responsibility for the amount not covered by insurance.
- authorize payment of medical benefits to Charleston Hematology Oncology Associates, PA for any medical and/or surgical services rendered to you.
- authorize this office to release any information acquired during an examination and treatment to your insurance company.
- authorize your physician or designated, qualified assistants to provide you with medical treatment. You consent to all medical or diagnostic care ordered for you. This consent includes testing for infections such as hepatitis B and HIV and providing blood or body fluids for such tests to protect you and/or those who provide you services.

I believe the above information is correct to the best of my knowledge.

Patient Signature

Date

Responsible Party Signature

Date