

# Oncology Specialists, S.C.

## Patient Information

MR # \_\_\_\_\_

Name		Date of Birth	
Street Address		City	State   ZIP
Social Security Number	Home Phone Number	Work Phone No.	
Employer			
Employer's Address (include City, State, ZIP)			

## Other Persons With Whom We May Discuss Your Personal Information

(Note: Without your signature below, we cannot communicate with anyone other than your referring physician and your spouse concerning any aspect of your care.)

Name of Spouse (indicate if unmarried)	Referring Physician
Other person we are authorized to discuss your case with: Name:	Phone Number:

Insurance– Do You Have an HMO or POS, which requires a Referral?  Yes  No

Insurer Name	Policy or ID Number
Name of Guarantor, if other than spouse	Guarantor's Employer - Name
Guarantor's Employer - Address	Guarantor's Work Phone
Name of Policy Holder	Group Number
Address for Claims	Phone Number for Providers

## Medical Information

Diagnosis	Primary Care Physician	Referring Physician
Pharmacy – Name	Pharmacy – Phone #	Radiation Oncologist

OS Physician	Chemotherapy Nurse	Form Completed By
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I authorize Oncology Specialists, S.C. to use the information provided above to assist in providing my care, and to discuss my case with the individuals named.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_, 2002  
Date