

Today's Date: _____

Time Patient called: _____

Time & Date Appt Scheduled: _____

Location: _____ Dr: _____

Appt Date: _____

Appt Time: _____

MR# _____

Patient Information

Hospital Consult: Y / N

Name:		DOB:		Sex: M or F	
Street:		City:		St:	Zip:
Home No.:		Work No.:		Cell No.:	
SS No.:		Is patient in a SNF or Rehab Facility? Y / N			

May we contact you at these numbers and /or leave a message? Home: Y / N Work: Y / N Cell: Y / N
Other persons with whom we may discuss your personal information by HIPPA guidelines

(Note: Please indicate individuals with whom we may discuss your health and billing information)

Name:	Relation:	Phone No.:
Name:	Relation:	Phone No.:
Name:	Relation:	Phone No.:

Insurance - Do you have an HMO or insurance that requires a referral? Y / N

Primary ins:	ID No.:	Group No.:	
Name of Guarantor:	Relation to pt:	SS No.:	DOB:
Secondary Ins:	ID No.:	Group No.:	
Name of Guarantor:	Relation to pt:	SS No.:	DOB:
Primary phone No.:		Secondary phone No.:	

Questionnaire: ___ mailed ___ walk in ___ fax ___ email

Records: ___ Bringing ___ Faxing ___ Mail/Overnight ___ None

Date sent _____ fax #/e-mail _____ Records in Carenet _____

Medical Information

Diagnosis	Primary MD:	Referring MD:
	Primary MD No.:	
OSSC MD:	Completed by:	Referring MD No.:

I authorize Oncology Specialists, S.C. to use this information provided above to assist in providing my care and to discuss my case with the individuals named.

Patient Signature _____

Date _____ 20____