MEDICAL ONCOLOGY ASSOCIATES OF SAN DIEGO

(Phone) (858) - 637 – 7888 (Phone) (619) – 582 – 7888 (Fax) (858) – 637 – 7887

4060 4th Ave #440 3075 Health Ctr Dr #102 230 Prospect Pl #210

San Diego, CA 92103 San Diego, CA 92123 Coronado, CA 92118

PATIENT REGISTRATION

DATE _____

FIRST NAME_____MIDDLE_____ HOME ADDRESS_____

LAST NAME_____ _____

SEX___ DATE OF BIRTH____/_____/_____ CITY_____STATE_____ZIP_____

PRIMARY LANGUAGE _____ EMAIL_____

MARITAL STATUS ___MARRIED ___SINGLE HOME PHONE (_____) _____

___DIVORCED ___WIDOWED CELL PHONE (_____) _____

WORK STATUS ___EMPLOYED ___RETIRED REFERRING PHYSICIAN_____

___OTHER_____ HOW DID YOU HEAR OF US?_____

EMPLOYER_____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

___COMMERCIAL ___MEDICAL ___MEDICARE ___OTHER_____

INSURANCE COMPANY_____

INSURED / CARD HOLDER'S NAME_____RELATIONSHIP_____

POLICY #_____ GROUP#_____ PHONE (_____) _____

SECONDARY INSURANCE

___COMMERCIAL ___MEDICAL ___MEDICARE ___OTHER_____

INSURANCE COMPANY_____

INSURED / CARD HOLDER'S NAME_____RELATIONSHIP_____

POLICY #_____ GROUP#_____ PHONE (_____) _____

EMERGENCY CONTACT

FIRST NAME_____MI_____ HOME PHONE (_____) _____

LAST NAME_____ CELL PHONE (_____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

RELATIONSHIP_____ SEX_____DATE OF BIRTH____/_____/_____

FIRST NAME_____MIDDLE_____ DAYTIME PHONE (_____) _____

LAST NAME_____ EMPLOYER_____

ADDRESS_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____ CITY_____ STATE_____ ZIP_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____

SIGNATURE DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____

SIGNATURE DATE

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BRIEF MEDICAL INFORMATION

FIRST NAME_____MI_____LAST NAME_____

DATE OF BIRTH____/_____/_____

Primary Physician: _____

Dominant Hand: □Right □Left

Do you have a pacemaker, stent, or any metal or clips implanted? □Yes □No

Do you take heart or blood pressure medication? □Yes □No

Do you take blood thinners? □Yes □No

Are you diabetic? □Yes □No

If yes, please list any medication:_____

Please list any known allergies: _____

_____

Please list any recent surgeries, including type of surgery and approximate date:

_____ _____

_____ _____

Please list any medications you presently take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL RECORDS

I hereby authorize

_____

_____

_____

(Name and Address of Physician, Hospital or Health Care Provider)

to furnish to

_____

(Name of Physician)

any and all medical records and information pertaining to my medical history and/or treatment.

CONFIDENTIALITY NOTICE: THE INFORMATION CONTAINED IN THIS RELEASE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW.

_____ _____ _____

Printed Name of Patient Signature of Patient Date

_____

Maiden/Previous Name

If signed by other than patient, indicate relationship and reason:

_____

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FINANCIAL POLICY FOR MEDICAL ONCOLOGY ASSOCIATES OF SAN DIEGO

Dear Patient,

Our office will be happy to bill your primary and secondary insurance carrier if the proper information has been provided. We will need to copy your insurance card at the time of your visit.

If you wish to bill your own secondary insurance, please use a copy of your itemized monthly statements. If you need assistance with the secondary billing procedure or if you have any questions regarding your account, please contact our Business Office.

Our office will bill your HMO insurance for services rendered. In addition, most HMO insurance companies require the patient to pay a co-payment at the time of service. Please inform our office if your insurance provider requires a “co-pay”.

Patients are responsible for the balance due in full if their insurance company fails to pay. If you feel that your insurance company has not responded to your claim, please contact your insurance company. It is your responsibility to assist with any problems that result from an unpaid claim. Also, be advised that if we are not notified of changes (i.e., group number, insurance address, HMO changes) or new insurance coverage, you will be responsible for payment in full.

Please contact our Business Office if you have any questions regarding our financial policy.

_____ _____ _____

Printed Name of Patient Signature of Patient Date

_____

Maiden/Previous Name

If signed by other than patient, indicate relationship and reason:

_____