ONCOLOGY ASSOCIATES OF SAN DIEGO

A MEDICAL GROUP

Dr. Robert M. Barone, M.D., F.A.C.S. Dr. Paul M. Goldfarb, M.D., F.A.C.S.

PATIENT REGISTRATION

DATE _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX ___ DATE OF BIRTH ____/____/____

PRIMARY LANGUAGE _____

MARITAL STATUS ____ MARRIED ____ SINGLE

___ DIVORCED ____ WIDOWED

WORK STATUS ____ EMPLOYED ____ RETIRED

___ OTHER _____

EMPLOYER _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

EMAIL _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF US? _____

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 _____

LAST NAME _____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

RELATIONSHIP _____

FIRST NAME _____ MIDDLE _____ LAST NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX _____ DATE OF BIRTH ____/____/____

DAYTIME PHONE (_____) _____

EMPLOYER ADDRESS

CITY _____ STATE _____

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