New Patient Acquaintance Form

Today's Date: _____ / _____ / _____ Physician you are seeing today:_____

Name: _____ _____ _____
Last First Initial

Address: _____ _____ _____
Street City/State Zip Code

Telephone: _____ _____ _____
Home Work Cell

Gender: ☐M ☐F Birth date: ___/___/___ Age:___ Status: Single☐ Married☐ Widowed☐ Separated☐ Divorced☐

Patient Employed By:_____ Occupation:_____

In case of emergency, who should be notified? _____ Phone:_____

LOCAL PHARMACY

Name: _____ Address: _____

DOCTORS TO COMMUNICATE WITH

Primary Care Physician: _____ Address: _____

Medical Oncologist: _____ Address: _____

Surgical Oncologist: _____ Address: _____

Other Physician: _____ Address: _____

PRIMARY INSURANCE

Person Responsible for Account:_____
Last First Middle

Relationship to Patient:_____Birth date:___/___/___

Address (if different from patient's):_____ _____ _____ Phone:_____
Street City/State Zip Code

Person Responsible Employed by:_____ Occupation:_____

Business Address:_____Business Phone:_____

Insurance Name: _____ Certificate # _____ Group/Plan #_____

Names of other dependents covered under this plan:_____

ADDITONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name:_____ Relation to Patient:_____ Birth date:___/___/___

Address (if different from patients'):_____ _____ _____ Phone:_____
Street City/State Zip Code

Subscriber Employed by:_____ Occupation:_____

Insurance Company:_____ _____ _____
Name Certificate/ID# Group / Plan#

Names of other dependents covered under this plan:_____

I hereby authorize the above physician to release information to my insurance carrier concerning my illness and treatments, and hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. Medicare patients are responsible for coinsurance and deductible if their physician is Medicare participating. I hereby assign, transfer and set over to the above named faculty practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for any medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice. Authorization to release information via e-mail: By providing your email address above, you agree to receive by electronic mail, information about your healthcare included protected health information.

_____ **Date:** _____/_____/_____