

INLAND HEMATOLOGY-ONCOLOGY MEDICAL GROUP
401-C East Highland Ave.
San Bernardino, CA 92404

PATIENT INFORMATION SHEET

						DATE:	ACCOUNT NO:	
PATIENT INFORMATION								
PATIENT NAME			SEX	AGE	DATE OF BIRTH	SOCIAL SECURITY		MARITAL STATUS
ADDRESS							PHONE	
CITY					STATE	ZIP CODE		
LICENSE #	STATE	OCCUPATION			EMPLOYER			
EMPLOYER ADDRESS							WK. PHONE	
SPOUSE'S NAME			SPOUSE'S OCCUPATION			SPOUSE'S EMPLOYER		
SPOUSE'S EMPLOYER ADDRESS				SPOUSE'S SS#		DOB:	PHONE	
RELATIVE OF EMERGENCY CONTACT (NAME & ADDRESS)					Relationship		PHONE	

RESPONSIBLE PARTY

NAME	RELATION TO PATIENT	SOC. SEC. #	DRIVER LIC. # STATE	EMERGENCY OR WORK #
ADDRESS				PHONE
EMPLOYER NAME & ADDRESS				PHONE

INSURANCE INFORMATION

INSURANCE COMPANY	PRIMARY POLICY #	GROUP #	RELATION TO PATIENT
INSURANCE COMPANY	SECONDARY POLICY #	GROUP #	RELATION TO PATIENT

DURABLE POWER OF ATTORNEY / ADVANCED DIRECTIVES

YES _____ NO _____

REFERRING PHYSICIAN _____ PRIMARY PHYSICIAN _____

CONSENT FOR RELEASE OF MEDICAL RECORDS AND DIRECT PAYMENT

AUTHORIZATION AUTHORIZATION

I hereby authorize and direct my insurance carrier to pay directly to the provider any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan.

I hereby authorize the provider to release to my insurance company any medical information necessary to process this claim.

X _____

X _____