Southeast Florida
Hematology – Oncology Group

Today's Date: _____

Last Name: _____ First Name: _____ Mid. Intl: _____
Date of Birth: _____ Gender: _____ Social Security #: _____-_____-_____
Street Address: _____
Bldg. /Apt: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____-_____Cell Phone: (_____) _____-_____
Marital Status (Please circle one): Divorced Married Partnered Separated Single Widowed
Race: _____ Religion: _____ Preferred Language: _____
Ethnicity: Hispanic_____ Non-Hispanic_____ Email: _____
Spouse's: First Name: _____Last Name: _____
Your Occupation: _____ Employer's Name: _____
Employer's Address: _____
City: _____ State: _____ Zip Code: _____Work Phone: (_____) _____-_____
Emergency Contact: First Name _____ Last Name: _____
Phone Number: (_____) _____-_____ Relationship: _____

Which physician referred you to our practice?
Name: _____ Phone Number: (_____) _____-_____
Street Address: _____
Suite Number: _____ City: _____ State: _____ Zip Code: _____

Who is your primary care physician?
Name: _____ Phone Number: (_____) _____-_____
Street Address: _____
Suite Number: _____ City: _____ State: _____ Zip Code: _____

Pharmacy Name: _____ Phone Number: (_____) _____-_____
Street Address: _____City: _____ State: _____ Zip Code: _____

I authorize the following people to have access to my medical information:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Primary Insurance Carrier:
Name: _____
Policy Holder Relationship to You: _____
Policy Holder Name: _____
Date of Birth: _____ Gender: _____
SS#: _____-_____-_____
Policy ID: _____ Group #: _____

Secondary Insurance Carrier:
Name: _____
Policy Holder Relationship to You: _____
Policy Holder Name: _____
Date of Birth: _____ Gender: _____
SS#: _____-_____-_____
Policy ID: _____ Group #: _____

I authorize Southeast Florida Hematology Oncology to view the history of medications prescribed from other physicians electronically. _____ (PLEASE SIGN)

I understand that unless other arrangements are made in advance or where applicable federal or state laws supersede, all fees are the responsibility of the patient and are due at the time service.

I authorize release of any medical or other information necessary to process medical claims for professional services rendered by this office and its health care providers.

I authorize the release of any of my medical information to any of my other doctors to ensure quality care, as well as those individuals I have listed above as authorized to have access to my medical information.

Patient Signature: _____ Date: _____