Patient # (office use only) _____

Date: _____

CHARLESTON ONCOLOGY
COMPASSIONATE CARE FOR CANCER AND BLOOD DISORDERS

Patient's Name: _____
First Middle Last

Social Security No: _____ **Race:** _____ **Sex:** M F **Marital Status:** ☐ Single ☐ Married ☐ Widow ☐ Divorced

Ethnicity: Hispanic ☐ **yes** ☐ **no** ☐ **non-specified** **Are you in a skilled nursing facility?** ☐ **yes** ☐ **no**
Are you currently enrolled in Hospice care? ☐ **yes** ☐ **no** **Do you have an Advanced Directive or Living Will?** ☐ **yes** ☐ **no**

Address: _____
No/Apt. Street City State Zip

Home Phone: _____ **Work Phone:** _____

Age: ____ **Date of Birth:** _____ **Email Address**: _____

Patient's Employer: _____
name & address of company

Spouse's Name: _____ **Date of Birth:** _____

Spouse's Social Security No: _____ **Phone:** _____

Person Responsible if other than patient: _____ **Relationship to Patient:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Referred by: _____ **Primary Care Physician:** _____

Primary Insurance Information: _____
Name of Insured

_____ _____ _____
Insurance Company Name ID Number Group No.

Secondary Insurance Information: _____
Name of Insured

_____ _____ _____
Insurance Company Name ID Number Group No.

By signing this consent, you:

- **accept personal responsibility for all services rendered to you. If your insurance company does not pay for the service(s) rendered, you accept personal responsibility for the amount not covered by insurance.**
- **authorize payment of medical benefits to Charleston Oncology for any medical and/or surgical services rendered to you.**
- **authorize this office to release any information acquired during an examination and treatment to your insurance company.**
- **authorize your physician or designated, qualified assistants to provide you with medical treatment. You consent to all medical or diagnostic care ordered for you. This consent includes testing for infections such as hepatitis B and HIV and providing blood or body fluids for such tests to protect you and/or those who provide you services.**

I believe the above information is correct to the best of my knowledge.

_____ _____
Patient Signature **Date**

_____ _____
Responsible Party Signature **Date**