Hematology & Oncology
RHODE ISLAND

PATIENT CONFIDENTIAL INFORMATION FORM

Name: _____Sex: ☐M ☐F DOB: _____

Full Address: _____

Phone: (____) _____ Cell: (____) _____ Work: (____) _____

Social Security # ___-___-____ Marital Status: ☐Married ☐Single ☐Divorced ☐Widower

Emergency Contact Name: _____ Phone: (___) _____

EMPLOYMENT INFORMATION

Employer: _____Type of Work: _____
Address: _____

INSURANCE INFORMATION

Primary Insurance Co. _____Policy # _____
Secondary Insurance Co. _____Policy # _____

If Insurance in another person's name, please complete below:
Name: _____SS # _____DOB _____

I understand that I am financially responsible for all charges for services provided to me including the balance remaining after payment of possible insurance benefits.
Patient's Signature: _____Date: _____

Assignment of Benefits: I hereby request payment of medical benefits to myself or to the doctor or party who accepts assignment.
Patient's Signature: _____Date: _____

Release of Information: I authorize the release of any medical information necessary to treat my medical condition or to process my insurance claims.
Patient's Signature: _____Date: _____