

**BUX-MONT ONCOLOGY HEMATOLOGY MEDICAL ASSOCIATES, PC  
PATIENT INFORMATION**

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Emergency Contact & Relationship to Patient \_\_\_\_\_ Phone Number \_\_\_\_\_  
Marital Status: S M W D S  
Patient Employer \_\_\_\_\_ Phone Number \_\_\_\_\_  
Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone Number \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Pharmacy Phone Number \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance**

Subscriber Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to Patient; \_\_\_\_\_ Social Security # \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

**Secondary Insurance**

Subscriber Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to Patient; \_\_\_\_\_ Social Security # \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_

**Additional Insurance**

Subscriber Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Relationship to Patient; \_\_\_\_\_ Social Security # \_\_\_\_\_  
Subscriber Employer: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

**Authorization**

- I authorize any holder of medical or other information about me to release this information to any insurance company, its intermediaries or carriers or another physician's office
- I hereby authorize direct payment of medical benefits to include major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to Bux-Mont Oncology Hematology Medical Associates, PC.
- I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.
- I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all personal balances.

DO YOU HAVE A LIVING WILL? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Responsible Party      Date

(FOR OFFICE USE ONLY: Date entered: \_\_\_\_\_ Entered by: \_\_\_\_\_)