Southwest Oncology CENTERS

PATIENT INFORMATION SHEET

Date: _____ **(PLEASE PRINT) (USE BLACK INK ONLY)** **Jacket #:**_____

☐ **Dr Grado** * ☐ **Dr Sapozink** * ☐ **Dr Danziger** * ☐ **Glendale** * ☐ **Scottsdale**

Patient's FULL LEGAL Name: _____ **SS#** _____
Last First Middle

Mailing Address: _____ **Phone:** _____ - _____ - _____
PO Box/Apt or Space # *City/Province/State/Zip* **Cell:** _____ - _____ - _____

Permanent / Temporary (Circle One) Address: _____ **Phone:** _____ - _____ - _____

E-Mail Address: _____ **Birth Date** _____/_____/_____ **Age:** _____ ☐ **Male** ☐ **Female**
Month Day Year

Employer: _____ **Occupation:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Legally Separated** ☐ **Divorced** ☐ **Widowed**

Spouse's Name: _____ **SS #** _____ **Birth Date:** ____/_____/_____

Address: _____ **Phone:** _____ - _____ - _____

Spouses Employer: _____ **Occupation:** _____

RESPONSIBLE PARTY: Name: _____
(NOTE: The responsible party is the person who is ultimately responsible for the medical bill)

Birth Date: ____/_____/_____ **SS #** _____ **Relationship:** _____

Address: _____ **Phone:** _____ - _____ - _____

Emergency Contact: _____ **Relationship:** _____

Address: _____ **Phone:** _____ - _____ - _____

Primary Care Physician: _____ **Phone:** _____ - _____ - _____

Address: _____ **Fax #:** _____ - _____ - _____

Referring Physician: _____ **Phone:** _____ - _____ - _____

Address: _____ **Fax #:** _____ - _____ - _____

ADVANCE DIRECTIVES—You have the right to prepare legal documents relating to: #1 your decision to refuse medical treatment you do not want; #2 requesting medical you do want; or #3 your ability to make medical decisions yourself.

Have you prepared any documents relating to the above 3 issues? ☐ **YES** ☐ **NO**
If yes, please provide a copy of the signed originals of the documents for inclusion in your medical files.

I understand that by proceeding with services I am responsible for payment of this account. The balance due may include deductibles, office visits, co-payments or other services not paid by insurance or other amounts determined to be patient responsibility. In the event of default, I also understand that collection costs and/or attorney fees may be charged to effect collection. Co-payments are due at time of service. Balances are due at time of billing.

Signature: _____ **Date:** _____
Patient or Responsible Party

INSURANCE INFORMATION

Please list all insurance coverage's which you expect to be filed for payment of services provided to you. If there are more than two insurance companies providing coverage, please request an additional form from our receptionist.

IF YOU CHANGE OR HAVE CHANGED INSURANCE COMPANIES, OR YOU BECOME ELIGIBLE FOR ANOTHER TYPE OF COVERAGE, PLEASE NOTIFY ONE OF OUR STAFF IMMEDIATELY!

Primary: Insurance _____

Policyholder _____
Note: The policyholder is the person whom the insurance was written; it could be you, your spouse or your parent.
Relation to Patient _____ Date of Birth ___/___/___ Effective Policy ID # _____ Date ___/___/___

Policyholder's Employer _____ Group ID # _____

Second: Insurance _____

Policyholder _____
Note: The policyholder is the person whom the insurance was written; it could be you, your spouse or your parent.
Relation to Patient _____ Date of Birth ___/___/___ Effective Policy ID # _____ Date ___/___/___

Policyholder's Employer _____ Group ID # _____

Prior Authorization Required?	☐ **YES**	☐ **NO**	**Are You Eligible for Medicare?**	☐ **YES**	☐ **NO**
Hospital Coverage Only?	☐ **YES**	☐ **NO**	**Do You Have Medicare Part A Only?**	☐ **YES**	☐ **NO**
Applied for AHCCCS/Medicaid?	☐ **YES**	☐ **NO**	**Medicare Replacement HMO Policy?**	☐ **YES**	☐ **NO**

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I hereby authorize *GORDON L GRADO, MD, INC* to furnish information to my insurance carrier(s) concerning my illness and treatments.

I hereby assign payment direct to *GORDON L GRADO, MD, INC* the surgical and/or medical benefits otherwise payable to me under the terms of my insurance. I understand that I am responsible for any amount not covered by insurance and that balances are due upon receipt of billing.

I hereby authorize photocopies of this form and my signature to be as valid as the original.

Signature: _____ **Date:** _____
Patient or Responsible Party

MEDICARE SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to *GORDON L GRADO, MD, INC* for any services furnished me. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Name: _____ **ID #:** _____

Signature: _____ **Date:** _____
Patient or Responsible Party

I authorize the Medicare Claim Administration to release to *GORDON L GRADO, MD, INC* claim information for services provided to me by the above named provider(s).

Medicare # _____ **Retired Railroad?** ☐ **YES** ☐ **NO**

Hospital (Plan A) _____ **Effective Date:** _____/_____/_____ **Medical (Plan B)** _____ **Effective Date:** _____/_____/_____