PATIENT INFORMATION

Patient Name _____ DOB _____

Street Address _____

City/State _____ Zip Code _____

Home Phone _____ Ofc Phone _____

Soc Sec # _____

Employer _____

Employer Address _____

Emergency Contact _____ Relationship _____

Street Address _____ City/State _____ Zip Code _____

Responsible Party _____ Relationship _____

Street Address _____ City/State _____ Zip Code _____

Home Phone _____ Ofc Phone _____

Soc Sec # _____

Referring Physician _____

INSURANCE INFORMATION

Primary Insurance Co _____

Street Address _____

City/State _____ Zip Code _____

Policy # _____ Group# _____

Subscriber _____ Relationship _____ DOB _____

Effective Date _____

Secondary Insurance Co _____

Street Address _____ City/State _____ Zip Code _____

Policy # _____ Group # _____

Subscriber _____ Relationship _____ DOB _____

Effective Date _____

INSURANCE AUTHORIZATION

I _____, hereby authorize Margaret N. Alexander, MD of Oncology for Women, to apply for benefits on my behalf for covered services rendered by her. I request that the payments from my insurance carrier be made directly to Margaret N. Alexander, MD of Oncology for Women. I authorize the release of medical information to my insurance company necessary for the processing of my claim. I or my insurance company may revoke, in writing, this authorization at any time. A copy of this authorization may be used in place of the original. **I understand that I or my estate are financially responsible for all charges not covered or denied by said insurance company. I understand, if I fail to pay my bill, my account will be forwarded to a collection agency. I or my estate are responsible for all collection charges and legal fees associated with my failure to pay my bill. * Please note that our office requires 24 hour notice for cancellation. You will be billed for missed appointments without prior notice.**

Signature _____ Date _____