

RADIATION MEDICAL GROUP, INC.

Form must be completed in ink

Patient Information

Name _____ Age _____ Date of Birth _____ Marital Status: S M D W

Address _____ Apt # _____ City _____ State _____ Zip _____

Mailing Address (if different) _____

Home Phone () _____ Work or Day Phone () _____ Cell Phone () _____

Sex: F M Driver's License # _____ State _____ Exp. _____

Employer: _____ Work Address _____

Are you enrolled in a Hospice Program? Y N Name of Program: _____

Are you a resident of a Skilled Nursing or Convalescent Facility? Y N Name of Facility: _____

Do you have a Designated Conservator or Power of Attorney (POA)? Y N Name: _____ Phone#:() _____

SPOUSE INFORMATION

Spouse Name _____ Date of Birth _____

Employed By: _____ Work or Day Phone () _____

Work Address _____ Cell Phone () _____

WHO TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN ABOVE PERSONS)

Name _____ Relationship to Patient _____

Home Phone () _____ Work Phone () _____ Cell Phone () _____

PHYSICIAN INFORMATION

Referring Physician _____ Office Phone () _____

Primary Physician _____ Office Phone () _____

Other Physician _____ Office Phone () _____

INSURANCE INFORMATION

Private or No Insurance – How do you intend to pay? CASH _____ CHECK _____ CREDIT CARD _____

Primary Insurance _____ Secondary Insurance _____

Subscriber Name _____ DOB _____ Subscriber Name _____ DOB _____

Member ID # / Policy # _____ Member ID # / Policy # _____

Employer / Group # _____ Employer / Group # _____

PLEASE SIGN & RETURN TO RECEPTIONIST

I, the undersigned, assign directly to Radiation Medical Group, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for copayments, deductibles, and coinsurance under the terms of my agreement with my health benefits plan and for any charges for services provided to me by Radiation Medical Group that are not covered services under my health benefit plan but which I nonetheless elect to receive. I authorize Radiation Medical Group, Inc. to release and/or obtain medical records as needed for my treatment or to assist in obtaining insurance reimbursement on my behalf.

Date _____ Signature _____