

Hematology & Oncology Associates of Rhode Island
1220 Pontiac Avenue, Cranston, RI 02920-4456
401-943-4660 Fax 401-943-0240

PATIENT CONFIDENTIAL INFORMATION FORM

Name _____ Sex: F M 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 _____ SSN _____ 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 _____