

# Patient Profile

Doctor: \_\_\_\_\_

## PATIENT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City,State: \_\_\_\_\_

Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other

Phone: \_\_\_\_\_ [ ]Home [ ]Work [ ]Other

Patient ID #: \_\_\_\_\_ Sex: [ ]M [ ]F

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Marital Status: [ ]Married [ ]Single [ ]Divorced

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

## PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

## HIPAA AUTHORIZED CONTACTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## GUARANTOR

[ ]Same as Patient

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City,State: \_\_\_\_\_

## EMPLOYMENT

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Company: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

Company: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**AUTHORIZATION OF PAYMENT:** I hereby assign all my insurance benefits under the described policies, and authorize Cancer Care of WNC to bill for charges incurred during the courses of treatment, and to provide any necessary information necessary to process this claim. I authorize payment be made directly to Cancer Care of WNC. A copy of this authorization may be used instead of the original. I understand that I am financially responsible for those charges not paid by my insurance. I authorize Cancer Care of WNC to inquire about and receive any information about any and all of my Medicare Part A and/or Part B claims, assigned and/or unassigned.

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

\_\_\_\_\_  
Date