

DIABLO VALLEY ONCOLOGY & HEMATOLOGY MEDICAL GROUP, INC.

PATIENT INFORMATION: PLEASE PRINT & FILL OUT COMPLETELY

Last Name _____ First Name _____ MI _____

Social Security Number _____ E-mail Address _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Home Phone _____ Alternate Phone _____

Physician You Are Here To See _____

Referring Physician _____

Primary Care Physician _____ Diagnosis _____

How did you hear about us? Referred by Physician Internet/Website Advertisement Other _____

PRIMARY INSURANCE COVERAGE

Insurance Company Name _____

Insurance Card is in the name of? Self Spouse Other _____

Complete the following information for the person whose name appears on the insurance card:

Last Name _____ First Name _____ MI _____

Social Security Number _____ Date of Birth _____

Group # _____ Plan Name _____

Policy ID # _____ Medical Group Name _____ Copay \$ _____

Does your insurance require a referral to see a specialist? NO YES (If so, please give referral slip to receptionist)

SECONDARY INSURANCE COVERAGE

Insurance Company Name _____

Insurance Card is in the name of? Self Spouse Other _____

Complete the following information for the person whose name appears on the insurance card:

Last Name _____ First Name _____ MI _____

Social Security Number _____ Date of Birth _____

Group # _____ Plan Name _____

Policy ID # _____ Medical Group Name _____ Copay \$ _____

Does your insurance require a referral to see a specialist? NO YES (If so, please give referral slip to receptionist)

IN CASE OF EMERGENCY: CONTACT

NAME _____

Relationship _____ Phone _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my physician and Diablo Valley Oncology & Hematology Medical Group, Inc. (DVOHMG) to submit insurance claims on my behalf. I authorize my insurance company or its carriers to disclose any information requested by my physicians regarding claims for medical services they provide me. I authorize John Muir Medical Center to release information requested by DVOHMG. I authorize DVOHMG to release information to physicians referred by DVOHMG. I authorize payments of assigned medical benefits to be paid directly to my physician and DVOHMG. I am responsible for deductibles, coinsurance, and non-covered items. I agree to pay any co-payments required by my insurance plan at the time of service. I understand that Diablo Valley Oncology does not bill tertiary insurance coverages other than Medicare or MediCal. (Rev10/28/09)

PATIENT'S SIGNATURE _____ **DATE** _____