HEMATOLOGY/ONCOLOGY ASSOCIATES
OF CENTRAL NEW YORK, P.C.

PATIENT DEMOGRAPHICS
Please Print and use only BLUE or BLACK Ink

Last_____ _____ **First**_____ **M**_____ **DOB** _____/_____/_____

Maiden/Other Name _____ **Marital Status**_____ **Sex:** ☐Male ☐Female

Home Address: _____**City**_____ **ST**_____ **Zip**_____ - _____

County_____ **Social security Number**: _____/_____/_____

Home Phone: (_____) _____-_____ **Cell Phone: (_____)** _____-_____ Email_____

Occupation:_____ ☐ Check if we can send our newsletter by email

Patient Employer: _____ **Work Phone**_____ **Retired**? ☐Yes ☐No

Patient work address: _____**City**_____ **ST**_____ **Zip**_____

Spouse/Relative: _____ **Spouse DOB**_____/_____/_____ **Spouse SS#**_____-_____-_____

Spouse Address: _____**City**_____ **ST**_____ **Zip**_____

Spouse Employer: _____**Spouse Work Phone**_____ **Retired**? ☐Yes ☐No

Spouse Employer Address_____**City**_____**ST**_____**Zip**_____

Emergency Contact: _____ **Emergency Phone**_____

Emergency Address: _____**City**_____ **ST**_____ **Zip**_____

Care Giver Primary:_____ **Relation:**_____ **Phone**_____

Referring MD/Phone_____ **Primary Care Provider/Phone**_____

Please Indicate Preferred Pharmacy: _____ **Phone:** _____

Pharmacy Address/Location_____

Insurance Information

☐**Please check if you have No insurance**

Medicare:
Recipient ID#_____ Hosp. Coverage Effective date_____ Med. Coverage effective date_____
Blue Shield:
Policy Holder Name_____ Relation to Pt _____ ID#_____
Group #_____ Coverage Type_____ Employer name_____ Effective date_____
Medicaid:
Recipient ID #_____ Coverage Code_____ County_____
Other Insurance:
Insured person_____ID#_____Ins Co Address_____
Disabled/Retired Disabled/Retired from_____ (Company) Date last Worked_____
(Circle One)

Medicare Only: I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claim. I request that payment under the medical insurance program be made to Hematology Oncology Assoc. of CNY for services performed to me indefinitely.

Signature_____ Date_____

All Patients: I hereby authorize Hematology-Oncology Associates of CNY to release any medical information concerning or relating to my health assessment or treatment to insurance companies and other third-party payers, health care providers and suppliers, pharmaceutical assistance programs, and state and federal agencies in connection with my health care or to secure payment for services or items furnished to me. I hereby authorize insurance companies and other third-party payers, including Medicare, to make payment of benefits directly to Hematology-Oncology Associates of CNY.

Signature_____ Date_____