SUMMIT
CANCER CENTERS

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information will be strictly confidential.

Name: ____ Male Female

Maiden name: _______________ (Circle one) Single Married Divorced Widowed Domestic Partnership

DOB: __________ Social Security Number: ___________________ Email address: __________________

Mailing address: ________________________________ City/State: ______________ Zip: ___________

Home phone: __________________ Cell phone: ________________ Place of birth: __________________

Employer: ____ Occupation: ______________________

How did you hear about us? ____

Referring physicians name: ______________________ Primary care physicians name: _________________

Preferred language: ___________________________ Ethnicity: Hispanic Not Hispanic/Latino Decline

Race (please circle): American Indian or Alaskan Native Black or African American Asian
Native Hawaiian or Other Pacific Islander Caucasian Hispanic or Latino

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NEAREST FRIEND/RELATIVE TO CONTACT IN CASE OF AN EMERGENCY

Name: ______________________________ Phone: ________________ Relationship: __________

Please list individuals we are authorized to speak to regarding your care/account.

Name: ______________________________ Phone: ________________ Relationship: __________

Name: ______________________________ Phone: ________________ Relationship: __________

Name: ______________________________ Phone: ________________ Relationship: __________

(Continued on reverse)

Person responsible for payment: (if patient is a minor under 18) ____________________________________

Mailing address: ________________________________City/State: ________________Zip: ______________

Phone: ______________________ Relationship to patient: _______________

Employer of responsible party: ____

PRIMARY MEDICAL INSURANCE: ____

Policy Number: _____________________________ Group Number: ___________

Subscriber name: ____________________ DOB: _______ Employer: __________________

SECONDARY MEDICAL INSURANCE: ____

Policy number: _____________________________ Group Number: ___________

Subscriber name: ____________________ DOB: _______ Employer: __________________

I have completed the above information to the best of my knowledge. I request that payment of authorization benefits be made on my behalf to Medical Oncology Associates, P.S., dba Summit Cancer Centers for any services furnished me. I authorize Summit Cancer Centers to release any medical information which may be requested to determine benefits through my above-named insurance carrier, prepaid medical plan, government agency or the Health Care Financing Administration. I understand that if any insurance does not pay in full for services provided by Summit Cancer Centers, I assume liability for the unpaid portion. This agreement shall be governed and enforced in accordance with the laws of the State of Washington. Jurisdiction and proper venue for enforcement shall lie in Spokane County, State of Washington.

PATIENT SIGNATURE: ___________________________________ DATE: ______________________________

MEDICARE ASSIGNMENT/SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made to Medical Oncology Associates, P.S., dba Summit Cancer Centers for any services furnished to me. I authorize any holder of medical information about me to the Centers for Medicare and Medicaid Services and its agents, any information needed to determine these benefits, or the benefits payable for related services.

PATIENT SIGNATURE: ___________________________________ DATE: ______________________________