Jackson Oncology ASSOCIATES
A Professional Limited Liability Company

PATIENT INFORMATION

JOA Dr._____Acct_____

PLEASE READ & FILL OUT (PRINT) COMPLETELY

*For Identification Compliance Purposes: Please present a valid government-issued photo ID (current driver's license, passport). If you don't have this or address isn't current, we need your Social Security Card & Proof of Residency (utility bill or rental/lease agreement in your name).

REFERRING Physician: _____ **PRIMARY CARE/Family Physician**: _____

First Appt Date: ___/___/___ **Patient Soc Security #**: _____ **Sex:** ☐ **M** ☐ **F** **Date of Birth:** __/__/___

****PATIENT NAME**: _____ **Address**: _____ **City**: _____ **St**:___ **Zip**: _____

****PATIENT PHONE:** **Home**: _____ **Work**:_____ **Cell**:_____

****PATIENT E-MAIL**: _____ **(for *CARESPACE Patient Portal Access)**

Marital Status: ☐ *Married* ☐ *Single* ☐ *Divorced* ☐ *Widowed* ☐ *Separated* ☐ *Other* _____

Race: ☐ *American Indian/Alaska Native* ☐ *Asian* ☐ *Black/African American* ☐ *White* ☐ *Other* _____

Ethnicity: ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino* ***Preferred Language**: ☐ *English* ☐ *Spanish* ☐ *Other* _____

Patient Employment Status: ☐ *Retired* ☐ *Employed* ☐ *Unemployed* ☐ *Other* _____

Employer Name: _____ **Address:** _____ **Phone:** _____

****SPOUSE Name:** _____ **Date of Birth:** __/__/___ **Soc Security #:** _____ **Phone:** _____

****SPOUSE Employment Status**: ☐ *Retired* ☐ *Employed* ☐ *Unemployed* ☐ *Other* _____

****SPOUSE Employer Name**: _____ **Address:** _____ **Phone:** _____

Is Patient currently in a Skilled Nursing Facility/Nursing Home? ☐ **Y** ☐ **N** **Name of Facility**: _____

Is Patient currently enrolled in a Hospice Program? ☐ **Y** ☐ **N** **Name of Hospice**: _____

****EMERGENCY Contact (Friend or Relative) NOT living with you:**

Name: _____ **Relationship**: _____ **Phone**: _____

PLEASE READ CAREFULLY---INSURANCE Assignment of Benefits & Financial Responsibility

You **MUST** provide insurance cards and information on **ALL** policies (including, but not limited to, Medicare, Medicaid, Group Medical, *Cancer and/or Hospital Only policies). A fee may be assessed if information is needed because insurance coverage was not disclosed to JOA.

PRIMARY Ins Name: _____ **Policy#:**_____ **Employer/Group#:**_____

Policyholder: _____ **SS#** _____ **Relationship:** __**Self** __**Spouse** __**Child** __ **Other DOB:** ___/___/___

SECONDARY Ins Name: _____ **Policy#:**_____ **Employer/Group#:**_____

Policyholder: _____ **SS#** _____ **Relationship:** __**Self** __**Spouse** __**Child** __ **Other DOB:** ___/___/___

CANCER/OTHER Ins Name: _____ **Policy#:**_____ **Employer/Group#:**_____

Policyholder: _____ **SS#** _____ **Relationship:** __**Self** __**Spouse** __**Child** __ **Other DOB:** ___/___/___

Authorization (Please read all & sign):

I request payment of benefits be made on my behalf to Jackson Oncology Associates for any services furnished to me by Jackson Oncology. I authorize any holder of medical information about me (including protected health information), to release to my insurance company and/or the Centers for Medicare and Medicaid Svcs and its agents, any information needed to determine benefits to Jackson Oncology for any services furnished to me **I understand I am financially responsible for payment regardless of insurance coverage**. I permit a copy of this authorization to be used in place of original.

Date: _____ **Patient/Authorized Guarantor Signature**: _____ **Relationship to patient**: _____