**Patient Demographic Sheet** Today's Date_____

[ ] New Patient [ ] Consult from another physician [ ] 2nd opinion requested by patient

Patient Name DOB Age Home phone

Home Address: City State Zip Code

Social Security Number

Patients Employer: Occupation Phone

Employers Address City State Zip Code

Referring Physician / Primary Care Physician

*Emergency Contact Information and their relationship to the patient*

Name Address Phone Relationship

Please let us know how you wish to be contacted in the following (check all that apply)

[ ] Home Telephone and OK to leave message with detailed information regarding your diagnosis and plan of care

[ ] Home Telephone and leave message with call back number only

[ ] Work Telephone _____

- [ ] OK to leave message with detailed information regarding your diagnosis and plan of care
- [ ] OK to leave message with call back number only

[ ] Cell phone_____

- [ ] OK to leave message with detailed information regarding your diagnosis and plan of care
- [ ] OK to leave message with call back number only

[ ] Email Account _____

- [ ] OK to leave message with detailed information regarding your diagnosis and plan of care
- [ ] OK to leave message with call back number only

[ ] Other / Family / Friend Name and Number _____

1. I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Surgical Oncology Associates of South Texas with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.
2. I have read, and or been advised to read, the entire financial policy.

Assignment and Release of Information

AS A COURTESY TO YOU, we will file your insurance claim. It is your responsibility to see that your insurance pays on time. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. If you fail to pay your bill this could result in turning your account over to a collection agency.

I hereby authorize my insurance benefits to be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician to release any information required.

Patients Signature Date