Central Coast Oncology and Hematology

Amy McMullen, MD
Michael Yen, MD PhD

Patient Information (Please print)

Name(Last, First, MI)				
SSN	Sex	Date of Birth		
Address		City/State	Zip	
Phone (H)	Phone (C)	Email		
Contact Preference **(Please circle)** Home Cell Both		Marital Status	Employer	
Race **(Please Circle)** American Indian/ Alaska Native Asian Indian Black/African American Chinese Filipino Japanese Korean Native Hawaiian Other Pacific Islander Prefer Not to Answer Samoan Vietnamese White/Caucasian	Hispanic Origin **(Please circle)** Cuban Mexican Non-Hispanic Other Hispanic/Latino/Spanish origin Prefer Not to Answer Puerto Rican		Language Preference **(Please circle)** English Spanish Other:_____ Special accommodations requested	
Primary Care Provider:		Referring Provider:		
Emergency Contact Name (Last, First, MI)				
Emergency Contact Phone		Relation to patient		
Primary Insurance Carrier		Member ID #		
Subscriber (if other than patient)		Subscriber DOB (if other than patient)		
Relation to patient		Phone number		
Secondary Insurance Carrier		Member ID #		
Subscriber (if other than patient)		Subscriber DOB (if other than patient)		
Relation to patient		Phone number		
Reason Medicare is secondary (if applicable)				
Tertiary Insurance Carrier		Member ID #		
Subscriber (if other than patient)		Subscriber DOB (if other than patient)		
Relation to patient		Phone number		
Person responsible for bill		Relation to patient		

The above information is true to the best of my knowledge. I authorize my insurance company to pay directly to Central Coast Oncology & Hematology. I understand that I am financially responsible for any balance, and it is my responsibility to see that my balance for services provided is paid within 60 days of the date of service.

Signature _____ Date_____

1669 DOMINICAN WAY • SANTA CRUZ, CALIFORNIA 95065 • TELEPHONE 831-475-2220 • FAX 831-475-2221

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Consent to Treat

I consent to any examination or procedure rendered me under the instructions of my physician. I recognize the physicians furnishing services to me are independent agents.

Initial _____

Assignment of Benefits to Physician

I hereby give authorization for payment of insurance benefits to be made directly to Central Coast Oncology & Hematology for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Our Managed Care patients will be responsible for all non-covered services as outlined by their plan. In the event of a default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Central Coast Oncology & Hematology to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Initial _____

Medicare Authorization to Pay Benefits to Physician

Beneficiary Name _____ HIC# _____

I request that payment of authorized Medicare benefits be made to me or on my behalf to Central Coast Oncology & Hematology for any services furnished to me. I authorize the holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Initial _____

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Address of Personal Representative

_____

Phone number of Personal Representative