



**Lebanon Hematology/Oncology Inc.**

670 N. Broadway St.

Lebanon, OH 45036

Phone 513-228-1552

Fax 513-228-1558

**PATIENT INFORMATION**

PATIENT'S NAME: \_\_\_\_\_ PREFERRED NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ Male / Female (circle one)

SS#: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ (do you want appointments to be verified by email? Yes No

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ HOW LONG: \_\_\_\_\_

CLOSE FRIEND OR RELATIVE NOT LIVING WITH YOU: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

IS THERE SOMEONE WE SHOULD CONTACT (OTHER THAN YOURSELF) REGARDING ANY BILLING ISSUES? NAME \_\_\_\_\_ PHONE#: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT: \_\_\_\_\_ PHONE#: \_\_\_\_\_

DO YOU HAVE A HOME CARE AGENT? Yes / No NAME: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_ LATEX ALLERGY: Yes No DIABETIC: Yes No

**SPOUSE INFORMATION**

SPOUSE'S NAME: \_\_\_\_\_ Male / Female (circle one)

ADDRESS: \_\_\_\_\_ SS#: \_\_\_\_\_

PHONE#: \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ HOW LONG: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INS. CO.: \_\_\_\_\_ POLICY#: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
\_\_\_\_\_  
SUBSCRIBER NAME: \_\_\_\_\_  
EFFECTIVE DATE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

(This is usually located on the back of the card)

2<sup>ND</sup> INS. CO.: \_\_\_\_\_ POLICY#: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ GROUP#: \_\_\_\_\_  
\_\_\_\_\_  
SUBSCRIBER NAME: \_\_\_\_\_  
EFFECTIVE DATE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

(This is usually located on the back of the card)

REFERRED BY: \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_

**Please read:** All charges are due at the time of services. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

INSURANCE AUTHORIZATION  
AND  
FINANCIAL RESPONSIBILITY

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Lebanon Hematology/Oncology Inc. for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorization release of medical information necessary to pay the claim. If item 9 or the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare/Other Insurance Company assigned cases, the physician or supplier agrees to accept the charge determination of the company as the full charge, and the patient or responsible party will be liable for the deductible coinsurance and non-covered services. I certify that the information I have given is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by my insurance.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_