

M | H
O | A

Matthews Hematology Oncology Associates

Richard S. Foulke, M.D.
Lance K. Lassiter, M.D.
Alfred J. Newman III, M.D.

Date: _____ MR #: _____

Patient Name: _____
Last First Middle

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____

Maiden Name: _____ Married: _____ Single: _____ Widow: _____ Divorced: _____

Referring Physician: _____ Phone #: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Preferred Pharmacy: _____ Phone #: _____

Primary Insurance Information

Name of Insurance Company: _____

Insured's Name: _____ Date of Birth: _____

Insured ID #: _____ Social Security #: _____

Insurance Address: _____

Secondary Insurance Information

Name of Insurance Company: _____

Insured's Name: _____ Date of Birth: _____

Insured ID #: _____ Social Security #: _____

Insurance Address: _____

I hereby authorize Matthews Hematology Oncology Associates to furnish my medical records to insurance carriers and physicians assisting in my care, concerning my illness and treatments. I hereby assign Matthews Hematology Oncology Associates all payments for medical service rendered to dependents or myself. I understand that these authorizations remain in effect as long as my dependent or I remain a patient.

Patient Signature: _____ Date: _____

Relationship if other than patient: _____