CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES

TODAY'S DATE _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____ Social Security #_____

Home Phone #_____ Cell Phone #_____

Place of Birth _____ Race _____ Marital Status_____

Mailing Address: _____ City _____ State _____ Zip _____

Local address during treatment if different _____ Local Phone #_____

EMPLOYER _____ Address _____

Occupation _____ Work Phone#_____

Name of Spouse _____ Date of Birth _____ Social Security #_____

Employer _____ Work Phone #_____ Cell #_____

Close Friend or Relative_____ Relationship_____ Phone #_____

Referring Physician _____ **Primary Care Physician** _____

Other Current Physicians_____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Name of Insured_____

Medicare Number _____

Secondary Insurance Carrier _____ Name of Insured_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Carson Tahoe Radiation Oncology Associates physician for the medical benefits for services rendered. I hereby authorize Carson Tahoe Radiation Oncology Associates to release any and all information necessary to process this claim.

SIGNED_____ DATE _____

Rev. 10/12/15