CAROLINA BREAST & ONCOLOGIC SURGERY

2223 Hemby Ln
Greenville, NC 27834
Phone: (252)413-0036
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PATIENT DEMOGRAPHIC FORM

Patient Information					
Last Name	First Name		MI	Date of Birth:	
Address	City			State	Zip Code
Home Phone	Work			Cell	
Best Number to be Reached: (*Please circle one*) Home Work Cell					
Email	Marital Status:			Social Security Number	
Gender: M or F	Ethnicity: Latino or Non-Latino				
Race: (Circle One) Am Ind/Alaska Asian Black/Af Am Pac Isl/Hawaiian White Other					
Employer Name	Work Phone				
Patient Medical Information					
Who referred you?	Clinic Location:		Phone:		
Primary Physician:	Clinic Location:		Phone:		
Emergency Contact					
Name:	Relationship to patient:		Phone:		

I do hereby certify that I (or my dependents) have insurance coverage with _____ and assign directly to Carolina Breast & Oncologic Surgery (CBOS) all insurance benefits, if any, for all professional services rendered. I understand that the Provider will file an insurance claim, if applicable, on my behalf with my insurance company. I fully understand that I am financially responsible for all charges for professional services rendered whether or not paid for or covered by my insurance company. I acknowledge that I have been given the opportunity to ask the Provider any questions I had pertaining to all the professional services rendered by the Provider. Furthermore, I acknowledge that the Provider cannot accept any responsibility for collecting my insurance claim or for negotiating a settlement on any disputed claim. **SHOULD FOR ANY REASON MY INSURANCE CLAIM BE DENIED OR UNPAID, I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY PROFESSIONAL SERVICES RENDERED NOT PAID BY MY INSURANCE COMPANY.** I hereby authorize CBOS to release all information necessary to secure the payment of insurance benefits. **I authorize the use of this signature on all insurance submissions and I understand and agree to Carolina Breast & Oncologic Surgery's Financial Policy.**

Print Name_____

Signature_____

Signature of Patient or Personal Representative

Date:_____

*Description of Personal Representative's Authority (attach necessary documentation)