ONCOLOGY CONSULTANTS PATIENT INFORMATION FORM

Please complete all sections below and email a signed copy to info@ocbahamas.com

Personal Information:

First Name ____ Last Name ______________________________ M.I. _________

Street Address ____ P.O. Box ____________________

City: ____ Country/State: ____

Phn: ________________________ (hm) Phn: _______________________ (wk) Phn: _________________________(cell)

Date of Birth (MM/DD/YYYY): _______________________ National Insurance Number (NIB): _______________________

Marital Status : Single Married Divorced Widowed

Email Address: ____

Employer: __________________________________

Medical History:

Name of referring Physician: ______________________________Chief Complaint: ________________________________

Insurance Information:

Primary Insurance Company: ____________________________________ Effective Date_______________________

Name of Insured: ____Relationship to Patient______________

Identification Number (ID): _____________________________________ Group Name/Number: ___________________

Secondary Insurance Company: ______________________________ Effective Date______________________

Name of Insured: ____Relationship to Patient______________

Identification Number (ID) ______________________________________ Group Name/Number: ___________________

Assignment of Benefits: I understand that I will be held financially responsible for all charges resulting from services provided. I hereby authorize all insurance companies, noted above, to make direct payment of medical and/or surgical benefits to **Oncology Consultants Ltd.** For the services provided to myself and/or my dependent. In addition, I authorize the release of any medical information necessary for the processing of these claims for payment.

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Patient (Guardian)/Insured's Signature

Please present the following documents with this registration form:

☐ Photo ID (i.e. license, national insurance card)

☐ Medical Reports and/or Results

☐ Insurance card (Front and back)

ONCOLOGY CONSULTANTS LTD, PO BOX N-9311, NASSAU STREET, NASSAU, BAHAMAS

***Guarantor Information*: To be completed and signed by someone <u>OTHER</u> than the patient.**

I the undersigned do hereby agree that I shall be responsible for any charges incurred with regards to the patient. I understand that by signing this form, that I have accepted responsibility for the payment of all charges.

Guarantor Name: ____

Address: _____________________________________ P.O. Box: _______________

Phn:________________(hm) Phn: ________________(wk) Phn: ______________(cell)

Email Address: ____

National Insurance Number (NIB): ______________________

Drivers License No. _________________________

Place of Employment: _____________________________________

Guarantor Signature: __________________________________

***Next of Kin*:**

Name: _______________________________ Relationship: ______________

Home Address: ____

P. O. Box: ______________________________

Email Address: ____

Phone Contact: ______________(hm) _____________(wk) ___________(cell)

Emergency Contact:

Name: _______________________________ Relationship: ______________

Home Address: ____

P. O. Box: ____________________________

Email Address: ____

Phone Contact: ______________(hm) _____________(wk) ___________(cell)