ONCOLOGY CENTER OF SOUTHWEST, P.A.

MEDICAL ONCOLOGY AND HEMATOLOGY

4712 DEXTER DRIVE, STE 200, PLANO. TX 75093 TEL: 972 758 2600 FAX: 972 758 2660
Tax ID Number: 752904149 NPI # 1639113996

FIRST ENCOUNTER INFORMATION

PATIENT'S LAST NAME________________ FIRST NAME ________________ MI _____

ADDRESS ________________________________

CITY ________________STATE ____ZIP__________ DATE OF BIRTH______________AGE ____SEX___

HOME PH ______________ CELLULAR ______________ WORK PH. ______________

PATIENT SOCIAL SECURITY NUMBER______________DRIVERS LICENSE NUMBER______________MARITAL STATUS__________

EMPLOYER________________________EMPLOYER'S ADDRESS______________
________________________CITY ______________STATE ____ZIP __________

INSURANCE INFORMATION

PRIMARY INSURED PERSON/RESPONSIBLE PARTY________________________SEX______

HOME ADDRESS OF INSURED/ RESPONSIBLE PARTY________________________

CITY______________STATE____ZIP__________ PATIENTS RELATIONSHIP TO PRIMARY INSURED/RESPONSIBLE PARTY______________

EMPLOYER________________________WORK NUMBER______________

INSURED'S SS NUMBER______________INSURED'S DOB______________

PRIMARY INSURANCE CO. NAME________________________

ID NO.______________GROUP NO.______________ EFFECTIVE DATE______________

PLAN? HMO : EPO : POS : PPO SUBJECT TO PRE-EXISTING CLAUSE? ________ REFERRAL AUTHORIZATION REQUIRED? ____________

TELEPHONE NUMBER TO VERIFY BENEFITS PRIMARY________________________

DATE VERIFIED ______________TIME __________ NAME OF INS CO. CONTACT ______________

OUT PT. BENEFITS: DEDUCTIBLE ____________INS. PORTION __________ OUT OF POCKET __________

OV/ LAB:CO-PAYMENT ______________ INS PORTION ____________

SECONDARY INSURANCE______________ TELEPHONE NUMBER TO VERIFY BENEFITS______________

ID NUMBER______________GROUP NUMBER______________

INFORMATION ABOUT SPOUSE: NAME ________________________ AGE __________ SEX ______

DOB ______________ SSN ______________ TEL (H) ______________ (W) ______________

EMERG CONTACT: NAME ________________________ TEL # ______________

REASON FOR REFRAL/ DIAGNOSIS ________________________________

	NAME	TELEPHONE NUMBER	FAX NUMBER
REFERRING PHYSICIAN			
PCP			
OTHER PHYSICIAN			