

# Jacksonville Hematology Oncology

501 South Ragsdale, 4<sup>th</sup> Floor  
Jacksonville, Tx 75766

## BASIC INFORMATION FORM

Today's Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's Full **Legal** Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Citizenship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State, Zip

Alternate Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City, State, Zip

Occupation: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Spouse SSN: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_

Spouse Employer Address: \_\_\_\_\_  
Street City, State, Zip

Spouse Work Phone: \_\_\_\_\_ Work Fax: \_\_\_\_\_

**NAME OF EMERGENCY CONTACT:** \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State, Zip

Relationship to Patient: \_\_\_\_\_

Do you have a **LIVING WILL** or **DO NOT RESUCITATE AGREEMENT**?  **YES**  **NO**

\*If yes, please bring a copy to your first appointment.

\*If no, the doctors will be very willing to discuss this with you during your appointment.

**Closest Relative or Friend (not living with you):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State, Zip

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PRIMARY INSURANCE COVERAGE (INCLUDING MEDICARE OR MEDICAID)**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Policy/ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Phone number for benefits verification: \_\_\_\_\_

Are you required by your insurance to use ETMC or Mother Frances Hospital for admissions and or lab work?  YES  NO

If YES, please indicate which one: \_\_\_\_\_

Are you required by your insurance to obtain a referral from your primary care physician to have services performed by our physicians?  YES  NO

If yes, did you obtain the referral from your primary care physician?  YES  NO

**ADDITIONAL INSURANCE COVERAGE (INCLUDING MEDICARE OR MEDICAID)**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Policy/ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Phone number for benefits verification: \_\_\_\_\_

**ADDITIONAL INSURANCE COVERAGE (INCLUDING MEDICARE OR MEDICAID)**

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name of Insurance Carrier: \_\_\_\_\_

Policy/ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Phone number for benefits verification: \_\_\_\_\_

One of our physicians has less than 5% interest in the Tyler P.E.T. Imaging Institute, L.P. and our physicians may, on occasion, based on medical necessity, refer patients to that facility.