SMOC
Southeastern Medical Oncology Center
Expert, compassionate cancer care close to home.

PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WHEN INFORMATION CHANGES)

Patient Name: _____ **Date of Birth:** _____
First M Last

Social Security #: _____ **Gender: M ☐ F☐**

Marital Status: S ☐ M ☐ SEP☐ D☐ OTHER☐ **Allergies** :_____

Ethnicity: _____ **Race: Hispanic/Latino Non-Hispanic/Latino Language:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Ph #: _____ **Cell #:** _____ **Preferred Contact #: Hm Cell Wk**

Employer: _____ **Work Phone:**_____ **Email :**_____

How did you hear about us: Doctor Referral _____ **Internet** _____ **Newspaper**_____ **Phone Book** _____ **Other** _____

Referring Physician: _____ **Primary Care Physician:** _____

Pharmacy :_____ **Street Address:**_____

City:_____ **Phone #:**_____

Advance Directives - Heath Care Power of Attorney ☐ DO NOT RESUSCIATE ☐ Living Will ☐
(Please bring a copy on your next visit)

SPOUSE

Name: _____ **Date of Birth:** _____

Social Security #: _____ **Address:** _____

City/State: _____ **Zip:** _____ **Home Phone:** _____

Employer: _____ **Work Phone:** _____

EMERGENCY

Contact/Relationship: _____ **Phone:** _____

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD FOR US TO COPY)

PRIMARY

Insurance Co.: _____ **Policy Holder/Relationship:** _____

Policy Holder's DOB: _____ **Policy Holder's SSN:** _____

SECONDARY

Insurance Co.: _____ **Policy Holder/Relationship:** _____

Policy Holder's DOB: _____ **Policy Holder's SSN:** _____

Pharmacy Insurance: _____

I request that direct payment of authorized Medicare/ and or commercial insurance benefits be made to Southeastern Medical Oncology Center, and the unpaid balance will be made by me. I further authorize the release of medical information to my physician(s) or my insurance companies that may be pertinent to my case.

_____ _____

Signature **Date**