Heartland Hematology & Oncology
412 West 42nd Street Kearney, NE 68845
Phone: (308) 865-2303 Fax: (308) 865-2304

Date: ________________ Patient's Name ______________________________________
(first) (middle initial) (last)

Patient Address: ____
(st/rt#/box#) (city) (state) (zip) (county)

Date of Birth: ___________________________ Sex: Male Female Marital Status: S M W D Other____

Social Security Number: __________________________ Patient Home Phone: ________________________

Patient Cell Phone: ____________________________ Job Title: ________________________________

Circle One: Full Time Part Time Retired Disabled Homemaker Student

Employer: ____ Employer Phone: ________________________

Employer Address: ____
(st/rt#/box#) (city) (state) (zip)

Spouse Name: ________________________________ Spouse DOB: ______________________________

Spouse SS #: _________________________________ Spouse Cell Phone: __________________________

Spouse Employer: ________________________ Spouse Job Title: _____________ Employer Phone _________

Employer Address: ____
(st/rt#/box#) (city) (state) (zip)

Responsible Party if Minor or Other Reason: ____

Responsible Party Address: ____
(st/rt#/box#) (city) (state) (zip)

Relationship (circle one) Parent Guardian Power of Attorney Other _________________________

Home Phone: _______________ Cell Phone: _______________ Social Security No: ___________________

Responsible Party Employer: ____

Responsible Party Employer Address: ____
(st/rt#/box#) (city) (state) (zip)

Insurance Information

Medicare Number ___________________________ Medicaid Number ______________________________

Primary Insurance Company Name ____

Address ____ Phone ____________________
(city) (state) (zip)

Policy # ______________________________________ Group ID # ________________________________

Subscriber Name (person who carries the insurance) ____

Please complete information on reverse side.

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Secondary Insurance Company Name____

Address ____ Phone ________________
(city) (state) (zip)

Policy # ______________________________ Group ID # __________________________

Subscriber Name (person who carries the insurance) ______________________________

Do you have a cancer policy? Yes No If yes, ask about help to get the claim processing information.

If you do not have insurance, how to you intend to pay for your services? Cash Check Credit Card

Pharmacy Information

Preferred Pharmacy: ___________________________ Phone ( )________________

Address: ____
(st/rt#/box#) (city) (state) (zip)

Nearest Friend or Relative Not Living with You (Emergency Contact)

Name: _________________________________ Home Phone Number: ________________

Relationship to Patient: ______________________ Cell Phone Number:______________

Address: ____
(st/rt#/box#) (city) (state) (zip)

All Medicare Patients Please Complete:

Are you a Veteran?
Yes ☐ No ☐

Did the VA refer you here for treatment?
Yes ☐ No ☐

Do you have a VA "Free Basis ID Card"?
Yes ☐ No ☐

Do you have a Federal Black Lung Card?
Yes ☐ No ☐

Are you covered by an employer's health insurance plan through your employment or that of a family member? (Not Retiree Coverage)
Yes ☐ No ☐

Is this medical Condition due to an accident of any kind? Yes ☐ No ☐
(If you answer yes please complete the following) Work Related ☐ Injured in your home ☐ Auto ☐ Other ☐

Your physician may request your permission for a healthcare provider not associated with the practice, (i.e. a physician resident in training) to accompany them during the office visit. If you deny the request, your physician will comply with the denial.

I authorize the release of my medical records from this office, as well as records obtained from other facilities pertinent to my treatment plan, to other medical facilities as necessary for continued care. I authorize Heartland Hematology & Oncology to take a photograph of me and keep this photograph in my file for identification purposes.

I authorize disclosure of portions of my medical record to my insurance provider to determine liability and to obtain reimbursement. I assign all medical/surgical benefits for which I am entitled to Heartland Hematology and Oncology, PC. I understand that CHARGES ARE PAYABLE AT THE TIME OF TREATMENT. I further understand that I am financially responsible for all charges whether or not paid by said insurance.

I hereby authorize Heartland Hematology and Oncology, PC to render medical services to me.

DATE ________________________ SIGNATURE ______________________________

Please complete information on reverse side.