

ORANGE COUNTY RADIATION ONCOLOGY, P.C.

2565 US Route 9W
Cornwall, NY 12518

Ref. Dr. _____ **NEW PATIENT INFORMATION** Date _____

Patient's Name (Please Print)		Birthdate	SSN#	Marital Status S M W D
Street Address		City & State	Zip Code	Home Phone#
Patient's Employer		Occupation		Bus. Phone# ext
Employers Address		City & State		Zip Code
Spouses Name		Birthdate	SSN#	
Spouses Employer		Occupation		Bus Phone#
Employers Address		City & State		Zip Code
Drug Allergies if Any				
Emergency Contact	Relation	Phone:	Your Cell #	

INSURANCE INFORMATION

Primary Insurance Co. _____

Policy# _____ ****WE WILL MAKE A COPY OF YOUR CARD**

Group# _____ Insured's Name _____

Secondary Insurance Co. _____

Policy# _____ Group# _____

PLEASE Be advised that any REFERRALS needed &/or CO-PAYMENTS are **YOUR** RESPONSIBILITY
_____ - Please initial that you have read and understand the line above.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read and completed the information on this sheet to the best of my knowledge to be true. **AND**

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Orange County Radiation Oncology (Uma B. Mishra, M.D.). A copy of this can be considered an original for insurance purposes.

Signed _____ Date _____