



# Personalized Hematology-Oncology of Wake Forest

Today's date:			Primary Care Physician:				
<b>PATIENT INFORMATION</b>							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div. / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:					Home phone no.: ( )		
P.O. box:	City:		State:		ZIP Code:		
Email:			Race:				
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Google	<input type="checkbox"/> Other			
Other family members seen here:							
Smoking:	yes	no	How much:	occasionally	1 pack	2 packs	more
Pharmacy Name:		Pharmacy Address:			Pharmacy phone no.: ( )		

<h2>Reason for your visit today:</h2>	
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## EMERGENCY CONTACT (Please DO NOT skip)

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Personalized Hematology-Oncology of Wake Forest, PLLC or insurance company to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	