Hayman Salib, M.D.

REGISTRATION INFORMATION

Salib Oncology
Medical Oncology / Hematology

Please Print Date: _____ Home Phone: _____

Patient (Last Name, First Name, Initial): _____

Responsible Party (if a minor): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse (or responsible party) Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Purpose of Visit: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security #: _____ Spouse's Social Security #: _____

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Name of Secondary Insurer (if any): _____

Contract #: _____ Group #: _____ Subscriber #: _____

☐ Medicare ☐ Medicaid Claim ID # _____

If Welfare, your #: _____ County of: _____

I prefer to: ☐ Pay my balance in full at time of service. ☐ Pay my balance in full upon receipt of first statement.
☐ Make payment arrangements prior to services being rendered.

In case of emergency,
who should be notified? _____ Phone: _____

Your Drugstore Name: _____ Phone: _____

How did you learn of our practice? _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable
(Provider's Name)

to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance

benefits, when received by and paid to _____
(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

Disclaimer for Patient: Patient is responsible for collection fees and or percentages assessed. Make note these fees are accrued by non-payment of debt.

Authorized Signature of Subscriber _____ Date _____