Norfolk Center for
Cancer Care & Hematology

Today's Date ______________________

Patient's Name: ____

Date of Birth: ____________________ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ S ☐ M ☐ D ☐ W ☐ Other

Address: ____

____

Home Telephone #: ______________________ Work Telephone #: ______________________

Emergency contact name and telephone #: ________________________________

Employer Name: ____

Primary Care Physician's Full Name: ________________________________

Primary Care Physician's Address: ________________________________

Primary Care Physician's Telephone #: ________________________________

Referred for today's visit by: ______________________ Authorization/Referral # ______________

	Primary Insurance	**Secondary Insurance**
Plan Name:		
Address:		
Telephone #:		
ID/Certificate/Claim #:		
Plan #/Group Name:		
Policy Holder:		

AUTHORIZATION FOR DIRECT PAYMENT TO FACILITY

AUTHORIZATION to PAY BENEFITS to PHYSICIAN: I hereby authorize payment directly to the above-named physician(s) of medical/ surgical benefits, if any, otherwise payable to me for this service.

Patient or Parent/Guardian Signature ______________________ Date ______________

NCCH-REG 04/03