

**KENTUCKIANA CANCER INSTITUTE**  
**OFFICE LOCATION: \_\_\_\_\_**

**Date:** \_\_\_\_\_

**Full Name:** \_\_\_\_\_  
**First** **Middle** **Last**  
*(Please do not use nicknames or abbreviations.)*

**I prefer to be called:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
**Street** **Apt**  
\_\_\_\_\_  
**City** **State** **Zip**

**Phone ( )** \_\_\_\_\_ **( )** \_\_\_\_\_  
**Home** **Work**

**Caucasian** \_\_\_\_\_ **African American** \_\_\_\_\_ **Other** \_\_\_\_\_

**Male** \_\_\_\_\_ **Female** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Single** \_\_\_ **Married** \_\_\_ **Divorced** \_\_\_ **Widowed** \_\_\_

**Name of Spouse** \_\_\_\_\_ **Work Number** \_\_\_\_\_

**Emergency Notification** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Surgeon** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Referring Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Place of Employment** \_\_\_\_\_

**Employer's Address** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **Name of Cardholder** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **Name of Cardholder** \_\_\_\_\_

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**Assignment of Insurance Benefits**

I hereby authorize direct payment of medical benefits to Kentuckiana Cancer Institute, PLLC for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**Authorization to Release Information**

I hereby authorize Kentuckiana Cancer Institute, PLLC to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

\_\_\_\_\_  
Patient/Guardian (Please Print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse (Please Print)

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date

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**Medical Record Request/Release**

I hereby authorize Kentuckiana Cancer Institute to obtain/request my complete medical records including diagnosis, treatment plans and laboratory and x-ray results.

\_\_\_\_\_  
Patient/Guardian (Please Print)

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse (Please Print)

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date