



PATIENT INSURANCE INTAKE FORM

The Farber Center for Radiation Oncology
21 West Broadway New York, NY 10007
(212) 300.0663
www.thefarbercenter.com

PATIENT INFORMATION

Last Name:	MI:	First Name:	Age:	[] Male [] Female
Address:				
City:	State:	Zip Code:		
Email:		Referred by:		
Home #:	Cell #:	Work #	EXT:	
SSN #:	Date of Birth:	Marital Status:		

EMPLOYMENT INFORMATION

Employer:
Occupation:

EMERGENCY CONTACT

Name:	Home Phone:	Cell Phone:
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INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Carrier:	Insurance Plan:
ID or Policy Number:	Group Number:
Name of Policy Holder (Subscriber)	Relation to patient
Social Security # Subscriber is other than Self	

SECONDARY INSURANCE

Insurance Carrier:	Insurance Plan:
ID or Policy Number:	Group Number:
Name of Policy Holder (Subscriber)	Relation to patient
Social Security # Subscriber is other than Self	

AUTHORIZATION FOR RELEASE OF INFORMATION AND DIRECT PAYMENT

I hereby authorize The Farber Center for Radiation Oncology to release my medical information necessary for filing claims for service carriers liable for such payments. I hereby authorize the insurance carriers to make payment of benefits directly to The Farber Center for Radiation Oncology. I understand that I, as the patient, am responsible for balances, co-payments, and deductibles that are not covered or are unpaid by my insurances.

Signature: _____

Date: _____