



Patient Name _____ Female Male Age _____

Address _____ Home Phone _____

City _____ Zip _____ SSN _____ - _____ - _____

Birth Date ____/____/____ Single Married Widowed

May we give any medical information/results to your spouse? Yes No

May we leave lab/x-ray results on your answering machine? Yes No

Occupation _____ May we contact you at work? Yes No

Employer _____ Phone # _____

Address _____

Referred By _____ Family M.D. _____

Name of Spouse or Parent _____

Spouse/Parent's SSN _____ - _____ - _____ Spouse/Parent's Birth Date _____

Spouse's Occupation _____ May we contact him/her at work? Yes No

Spouse's Employer _____ Phone # _____

Address _____

Person not living in your household to contact in case of an emergency:

Name _____

Relationship to patient _____

Address _____ Home Phone _____

City _____ Zip _____ Work Phone _____

Primary Insurance Name _____

Policyholder/Sponsor Name _____ Birth Date _____

Policy ID# _____ Group Name and/or Military Branch# _____

Secondary Insurance Name _____

Policyholder/Sponsor Name _____ Birth Date _____

Policy ID# _____ Group Name and/or Military Branch# _____

To Our Patients:

Fees for services rendered are payable at the time of service unless previous arrangements have been made, or hospitalization is required. We accept assignment for Medicare and most insurance plans. I have read and give my consent for benefits to be paid directly to the above named doctors when lifetime assignment is indicated. I hereby authorize medical and billing information to be released to my insurance company.

Patient Signature _____ Date _____

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