

Uladzislau (Vlad) Naidzionak, M.D.

Diplomate Medical Oncology Diplomate Hematology Diplomate Internal Medicine

San Diego Oncology Medical Clinic

Address: City: State: Zip:	Name:			Birth Date:		Sex:	M / F	
Home Phone#: (Last Name	First	Mi					
Okay to leave messages: Home: Cell: E-mail: Social Security #: Driver's License #: Ethnicity: Employer Information: Name	Address:	City:		,	State:	Zip:		
Social Security #: Driver's License #: Ethnicity: Employer Information:	Home Phone#: () Work #: ()				Cell #: ()			
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Spouse Information: Name Cell Phone #	Social Security #:	Dr	#:	Ethnicity:				
Spouse Information: Name Cell Phone #	Employer Information:	N.I.						
Other Emergency Contact: Name Phone # Relation DOB		Name	Addre	ess		Occupation		
Other Emergency Contact: Name Phone # Relation DOB	Spouse Information:	Name		Call Phone #				
Referring / Primary Care Physician: Name Address Telephone	Otlean Francisco Control			Cell Phone #				
Current Pharmacy: Name Name Name Name Name Name Name Address Telephone I hereby authorize San Diego Oncology Medical Clinic to release any information necessary to process my insurance claim an assign San Diego Oncology Medical Clinic all insurance payments for medical services rendered on my behalf. I understand that insurance eligibility and benefits is not a guarantee of payment, and that payment is determined only when the claim is processed by the insurance carrier. I understand that I am responsible for knowing and understanding my benefits including deductibles, co-pays, out of pockets and visit limitations and I agree to assume financial responsibility for them; and if for an reason my insurance is terminated and/or changed, I automatically become liable for all financial occurring charges. I arresponsible for notifying San Diego Oncology Medical Clinic of any changes in the above information and/or insurance changes. Privacy Practice I acknowledge that I have been provided access to San Diego Oncology Medical Clinic's Notice of Privacy Practices and carrequest a copy from the front office if desired. I understand that if I have any questions regarding the privacy practices, I have the right to have them explained to me.	Other Emergency Contact:	Name		Phone #	Rel	ation	DOB	
Current Pharmacy: Name Name Name Name Name Name Name Address Telephone I hereby authorize San Diego Oncology Medical Clinic to release any information necessary to process my insurance claim an assign San Diego Oncology Medical Clinic all insurance payments for medical services rendered on my behalf. I understand that insurance eligibility and benefits is not a guarantee of payment, and that payment is determined only when the claim is processed by the insurance carrier. I understand that I am responsible for knowing and understanding my benefits including deductibles, co-pays, out of pockets and visit limitations and I agree to assume financial responsibility for them; and if for an reason my insurance is terminated and/or changed, I automatically become liable for all financial occurring charges. I arresponsible for notifying San Diego Oncology Medical Clinic of any changes in the above information and/or insurance changes. Privacy Practice I acknowledge that I have been provided access to San Diego Oncology Medical Clinic's Notice of Privacy Practices and carrequest a copy from the front office if desired. I understand that if I have any questions regarding the privacy practices, I have the right to have them explained to me.	Referring / Primary Care Phy	rsician:						
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