S.Y. Thomas Song, M.D.
Diplomate Medical Oncology
Diplomate Internal Medicine

Uladzislau (Vlad) Naidzionak, M.D.
Diplomate Medical Oncology
Diplomate Hematology
Diplomate Internal Medicine

San Diego Oncology Medical Clinic

Name: _____ Birth Date: _____ Sex: M / F
Last Name First Mi

Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: (___)_____ Work #: (___)_____ Cell #: (___)_____

Okay to leave messages: Home:_____ Cell:_____ E-mail:_____

Social Security #:_____ Driver's License #: _____ Ethnicity:_____

Employer Information: _____
Name Address Occupation

Spouse Information:_____
Name Cell Phone #

Other Emergency Contact:_____
Name Phone # Relation DOB

Referring / Primary Care Physician:_____
Name Address Telephone

Current Pharmacy:_____
Name Address Telephone

I hereby authorize San Diego Oncology Medical Clinic to release any information necessary to process my insurance claim and 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 any reason my insurance is terminated and/or changed, I automatically become liable for all financial occurring charges. I am responsible for notifying San Diego Oncology Medical Clinic of any changes in the above information and/or insurance changes.

Initial:_____

Privacy Practice

I acknowledge that I have been provided access to San Diego Oncology Medical Clinic's Notice of Privacy Practices and can request 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.

Initial:_____

Signature: _____ Date: _____

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