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Phone: 937-558-3500 • Fax: 937-558-3507

Date: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
SS#: _____ Sex: Male Female Marital Status: Single Married
Street Address: _____ Widowed Other
City: _____ State: _____ Zip: _____ Home Phone: _____
Is this your billing address as well? Yes No
If no, please provide address: _____
Employer: _____ Occupation: _____
Work Address: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

INSURANCE INFORMATION

Please present your insurance card and driver's license for us to make copies.

Primary Insurance: _____ Address: _____
ID#: _____ Group#: _____ Plan #: _____
Subscriber's Name: _____ Date of Birth: _____
Subscriber's SS#: _____ Relationship to Patient: _____
Effective Date: _____ Amount of Copay: _____
Secondary Insurance: _____ Address: _____
ID#: _____ Group#: _____ Plan #: _____
Subscriber's Name: _____ Date of Birth: _____
Subscriber's SS#: _____ Relationship to Patient: _____
Effective Date: _____ Amount of Copay: _____

CONTACT INFORMATION

Preferred phone number for contacting you about appointments or results: _____
A message may be left at my home Yes No
A message may be left at my place of employment Yes No
A message may be left on my voice mail Yes No
Alliance Physicians, Inc. (dba Cancer Specialists of Greater Dayton) may be identified as the caller. Yes No
EMERGENCY CONTACT: _____ PHONE: _____ Relationship: _____

MINOR/GUARDIAN INFORMATION

If patient is a minor, Parent/Legal Guardian's Name: _____
Address: _____
Home Phone: _____ Work Phone: _____
GUARDIANSHIP AUTHORIZATION: I give _____, my permission to
bring my child, _____, to Alliance Physicians Inc. (dba Cancer Specialists of Greater
Dayton) for medical care/treatment. _____ (signature of parent/legal guardian)
I give Alliance Physicians, Inc. (dba Cancer Specialists of Greater Dayton) my permission to evaluate and treat
my child, _____, in my absence.
_____ (signature of parent/legal guardian)

PLEASE COMPLETE BACK OF FORM

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a Notice of Privacy Practices from Alliance Physicians, Inc. (dba Cancer Specialists of Greater Dayton) Yes No

_____ (signature of patient, parent/legal guardian) _____ (Date)

LIVING WILL

I have a Living Will: Yes No

_____ (signature of patient) _____ (Date)

AUTHORIZATIONS

YOU HAVE MY PERMISSION TO DISCUSS MY MEDICAL RECORD INFORMATION AND ACCOUNT WITH THE FOLLOWING FAMILY MEMBERS:

_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

- I hereby authorize Alliance Physicians, Inc. (dba Cancer Specialists of Greater Dayton) to apply for benefits on my behalf for covered services rendered by the physicians or their orders, realizing that I am responsible to pay for my medical services, any collection agency fees, or attorney fees. I request that payment from my insurance company be made directly to the physician.
- I hereby authorize the release of any pertinent medical information to insurance carriers from Alliance Physicians, Inc. (dba Cancer Specialists of Greater Dayton) or consulting physicians.
- I hereby authorize Alliance Physicians, Inc. (dba Cancer Specialists of Greater Dayton) to release pertinent medical information to consulting physicians.
- I certify that the information I have reported with regard to my insurance company is correct. Either my insurance company or I may revoke this authorization at any time in writing.
- I permit a copy of any of these authorizations to be used in place of the original.

Signature: _____ Date: _____

(Patient / Legal Guardian)