



Lake Norman Oncology
 Huntersville • Mooresville

NEW PATIENT INFORMATION FORM

MR # _____

Appt. Date: _____

Richard Krumdieck, M.D.

David A. Eagle, M.D.

Timothy Kuo, M.D.

Patient Name _____
Last First Middle Initial

Address _____

City _____ State _____ Zip _____

Employed: YES NO Employer _____ Employer Phone _____

Home Phone _____ Cell Phone _____ Work Phone _____
Leave Message YES NO

Date of Birth _____ Social Security # _____

Maiden name or preferred nick name _____ Marital Status: MARRIED SINGLE OTHER

Referring Physician _____

Reason for referral _____

Emergency Contact _____ Relationship to patient _____

Emergency Contact Home Phone _____ Emergency Contact Work Phone _____

Preferred Pharmacy _____ Location _____

Phone _____ Fax _____

Insurance Information:

Primary Ins. Co. _____

Secondary Ins. Co. _____

Insurance Id# _____

Insurance Id# _____

Group # _____

Group # _____

Employer _____

Employer _____

Policyholder's Name _____

Policyholder's Name _____

Policyholder's Date of Birth _____

Policyholder's Date of Birth _____

Policyholder's SS# _____

Policyholder's SS# _____

I give consent for Lake Norman Hematology Oncology Specialists staff to perform routine office procedures, services, treatment, examinations and diagnostic procedures required during my visit. I hereby authorize Lake Norman Hematology Oncology Specialists to furnish and/or receive my medical records to/from insurance carriers and any physician assisting in my care concerning my illness and treatments. I hereby assign Lake Norman Hematology Oncology Specialists all payments for medical services rendered to myself or dependents. I understand that these authorizations will remain in effect as long as my dependent or I remain a patient. I understand that I will be responsible for all charges not covered by insurance.

Patient signature _____ Date _____

Relationship if other than patient _____