# CONFIDENTIAL

SUMMIT
CANCER CARE

**Fax: 912-354-5079 or Call 912-651-5550**
**Attention: Debbie Griffin**

☐ **Ronald Goldberg, MD** ☐ **LE. Robertson, MD** ☐ **Barry D, Luskey, MD**

## New Patient Information

☐ **Mark A. Taylor, MD** ☐ **Chris E. Haberman, MD** ☐ **Grant C. Lewis, MD**

☐ Physician Requested_____ ☐ Any Member of Group

Diagnosis: _____

Referring Physician:_____ Phone: _____

Contact Person:_____ Phone: _____

Patient Name:_____ Home Phone:_____

Street Address:_____ Alternate Phone:_____

City:_____**County**_____ State:_____ Zip code:_____ Sex: ☐M ☐F

SS#_____ DOB: _____

**Primary Insurance**: _____
Does insurance require referral? ☐Yes ☐No How many visits does it cover? _____ Exp. _____
If yes, referral number / authorization is_____ Insured's SS #_____
Primary Care Physician_____Primary Care Physician Phone_____

**Secondary Insurance**: _____
Does insurance require referral? ☐Yes ☐No How many visits does it cover? _____ Exp._____
If yes, referral number / authorization is_____ Insured's SS #_____
Primary Care Physician_____Primary Care Physician Phone_____

***If Malignancy Related Diagnosis:***
Previous biopsy or surgery? ☐Yes ☐No If yes, where? _____
Recent x-rays? ☐Yes ☐No If yes, where? _____

***If Hematology Related Diagnosis:***
Previous Pathology? ☐Yes ☐No If yes, where? _____
Recent blood work? ☐Yes ☐No If yes, where? _____

***Requested items to be faxed:***
***New Patient Information form***
***Insurance Card***
***Referral Number/Signed Authorization***
***Medical records including any pathology, lab work and diagnostic imaging reports.***

**For Summit Cancer Care use only**

**Date Consult received**_____ **Date completed**_____ **Received Ins Care** _____
**Appointment Date:** _____ **Physician scheduled**_____ **Received Ref/Auth form**_____
**Appointment Time:** _____ **Initials:** _____ **Received Records** _____