Prostate ONCOLOGY SPECIALISTS

MARK SCHOLZ, MD | RICHARD LAM, MD | JEFFREY TURNER, MD |

4676 Admiralty Way, Suite 101, Marina del Rey, CA 90292 || Phone: 310 827 7707
Fax: 310 574 4002 || mail@prostateoncology.com || www.prostateoncology.com

New Patient Application: Please complete this form and send back to our office ASAP

Today's Date: _____ How Did You Hear About Us / Referred By?_____

Patient: _____
First Name Middle Initial Last Name

Date of Birth: _____ Age: _____ Marital Status: _____ Spouse: _____

Social Security Number: _____ Emergency Name/Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Fax Number (must be dedicated line)_____

Mobile Phone Number: _____ Work Phone Number: _____

E-mail Address: _____

Occupation: _____ Employer: _____

INSURANCE INFORMATION: INCLUDE COPIES OF INSURANCE CARDS (FRONT AND BACK)

Primary Insurance: _____ Secondary Insurance: _____

ID Number: _____ ID Number: _____

Group Number: _____ Group Number: _____

Provider Phone Number: _____ Provider Phone Number:_____

HOW WOULD YOU LIKE TO CONSULT?

___IN **OFFICE**

THESE TYPE OF VISITS BELOW ARE $1200 - NOT USUALLY REIMBURSED BY INSURANCE COMPANIES.

___ VIA **TELEPHONE** Number would you like us to call? _____

___ VIA **FACETIME** Apple Account phone number or email? _____

___ VIA **SKYPE** Skype name or email? _____

MEDICAL INFORMATION:

Last Three (3) PSA Results:

Date			
PSA Results			

Current Therapy:

_____

_____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OFFICE USE ONLY:

Received? _____ **Scheduled Date/Time:_____MD:_____**

_____Entered in CGM **_____Patient Notified of 48 Hour Cancellation Fee?**

_____Insurance Verified and Entered? **_____Sent out New Patient Packet? _____ Delivery Method?**

_____Patient Informed about Consult Fee, if applicable?