

Registration Form

Name: _____ Social Security #: _____

Address: _____

City _____ State _____ Zip code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

DOB: ___/___/___ Age: _____ Marital Status: M S D W Sex: Male/Female

Employer: _____ Phone: (____) _____

Address: _____ Zip Code: _____

Person to notify in case of emergency: _____

Phone: (____) _____ Relationship: _____

Who referred you to our practice? _____ Phone: (____) _____

Address _____ City _____ State: _____ Zip _____

Who is your family practice doctor? _____ Phone: (____) _____

Address _____ City _____ State: _____ Zip _____

Please give us your insurance card(s) and driver's license so we can make a copy of them.

Primary Ins: _____ Secondary Ins: _____

U.S. Citizen ___ Yes ___ No If not, which country are you from: _____

Do you have Cancer ___ Yes ___ No Who is your Oncologist: _____

All patients MUST provide some form of identification.

Please read and sign the following statements

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician or supplier for services described in the insurance claim. I understand that my insurance plan(s) MAY NOT COVER THE TOTAL COST OF TREATMENT (DUE TO THE NATURE OF THE INSURANCE PLAN OR THAT SOME TREATMENT(S) MAY BE CONSIDERED MEDICALLY NECESSARY BY THE INSURANCE COMPANY) AND THAT **I AM RESPONSIBLE FOR ANY COPAYMENT, DEDUCTIBLE AND OTHER CHARGES NOT COVERED BY MY PRIMARY OR SECONDARY INSURANCE PLAN(S).**

Medicare patients: I understand that I am responsible for the deductible and the copayment applied to my Medicare Insurance coverage.

Signature: _____

Date: _____
