CT ONCOLOGY GROUP
PATIENT REGISTRATION

PLEASE PRINT **PLEASE COMPLETE FORM ENTIRELY** **DATE**:_____

NAME:_____ **BIRTH DATE**:_____

ADDRESS:_____ **CITY**:_____

STATE:_____**ZIP CODE**:_____**TEL#**:_____ **CELL#**:_____

Sex:_____ Single:____ Married:____ Widowed:____ Divorced:____

Ethnicity:_____ **Preferred Language**:_____

Patient's Soc. Security #:_____

Email:_____
Can we contact you by email to confirm appointments and for general information? Yes____ No ____

EMPLOYER:_____ Phone:_____
Employer's Address:_____
Occupation:_____

Who referred you to our office?_____
Who is your **primary care physician**?_____

Spouse's Name:_____ **Spouse's Birth Date**:_____
Spouse's Soc. Security#:_____

Emergency Contact:_____Home Phone:_____
Relationship to Patient:_____ Work Phone:_____

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INSURANCE:_____ Policy #:_____

Subscriber Name:_____ Relationship to Subscriber:_____

Subscriber's Date of Birth: _____ Subscriber's Employer:_____
Subscriber's Soc. Security #:_____

OTHER HEALTH INSURANCE:_____ Policy#_____

Subscriber Name:_____ Relationship to Subscriber:_____

Subscriber's Date of Birth: _____ Subscriber's Employer:_____
Subscriber's Soc. Security #:_____

(PLEASE PROVIDE COPIES OF ALL INSURANCE CARDS)

Do you have prescription coverage? Yes ____ No ____
Name of Prescription Company:_____

PHARMACY PREFERENCE:_____Town**:**_____

PLEASE COMPLETE NEXT PAGE

PATIENT AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration, Centers for Medicare & Medicaid Services (CMS), or to any private insurance company or other entity acting on my behalf , any information needed for this or a related medical claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to CMS/private carrier assignment of benefits apply.

I further certify that the information provided by me is true, accurate and complete.

_____ _____

Signature of Patient Date

PHYSICIANS/DENTISTS

Please list all other physicians and dentists that have participated in your care:

Physician Name	Address	Phone #
_____	_____	_____
	_____	
	_____	
_____	_____	_____
	_____	
	_____	
_____	_____	_____
	_____	
	_____	
_____	_____	_____
	_____	
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_____	_____	_____
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	_____	