



PATIENT REGISTRATION

NAME	SS#		
ADDRESS	DATE OF BIRTH	MARITAL STATUS S M W SEP D	
	STATE	ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	
REFERRED BY	ADDRESS	TEL#	
SPOUSE'S NAME	EMAIL		
SPOUSE'S EMPLOYER NAME/ADDRESS			
EMERGENCY CONTACT	TEL#	RELATIONSHIP	
PATIENT EMPLOYER INFORMATION			
EMPLOYER NAME	TEL#		
EMPLOYER STREET ADDRESS	CITY/STATE	ZIP	
PATIENT OCCUPATION			
INSURED PERSON (IF NOT PATIENT)			
EMPLOYER NAME	TEL #		
EMPLOYER STREET ADDRESS	CITY/STATE	ZIP	
INSURED'S RELATIONSHIP TO PATIENT		INSURED'S DATE OF BIRTH	
INSURANCE			
PRIMARY INSURANCE CO. NAME	MEDICARE # (IF APPL)		
ID#	GROUP #	PHONE #	
SECONDARY INSURANCE CO. NAME			
ID#	GROUP #	PHONE #	
AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT			
<p>I request that payment of authorized benefits be made to Eastchester Center for Cancer Care on my behalf for any services furnished to me by Eastchester Center for Cancer Care, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or my other insurance companies and their agents any information needed to determine these benefits or other benefits for related services.</p> <p>I certify that the information I have reported with regard to my insurance coverage is correct.</p> <p>I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.</p>			
DATE		SIGNATURE	



PATIENT CONSULTATION INFORMATION SHEET

REFERRING PHYSICIAN INFORMATION		
NAME	ADDRESS	PHONE
DIAGNOSIS	PRIOR TREATMENT	
SURGERIES AND HOSPITAL WHERE PERFORMED		
PRIMARY CARE PHYSICIAN INFORMATION		
NAME	ADDRESS	PHONE
SURGEON INFORMATION (IF NOT REFERRING PHYSICIAN, ABOVE)		
NAME	ADDRESS	PHONE
RADIOLOGY TESTS:	PATHOLOGY:	BLOODWORK:
INSURANCE INFORMATION		
REFERRAL INFORMATION, FIRST VISIT	CO-PAY REQUIRED/AMOUNT?	DRUG PLAN?
INSURANCE VERIFIED	EFFECTIVE DATE	SIGNATURE
APPOINTMENT INFORMATION		
SCHEDULED WITH DR. _____ ON _____ DATE _____ TIME		

PRIVACY PRACTICES ACKNOWLEDGEMENT

Acknowledgement:

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Birthdate _____
Please print legibly

Signature _____
Of patient, or if minor, parent or legal guardian

Date _____