CANCER CENTER AT GAITHERSBURG

REGISTRATION FORM

Date Dr. Ref Dr. Chart #

PATIENT INFORMATION

Patient's Last Name	First	Middle Initial	Email Address

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Date of Birth (DD/MM/YYYY)	Sex	Social Security No.	Home Phone No. AND Cell Phone No.
	○ M ○ F		( ) - ( ) -

Address	City	State	ZIP Code

Occupation	Employer	Employer Phone No.
		( ) -

Employer Address	City	State	ZIP Code

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance	Policy Number	Plan/Group Number

Subscriber's Name	Subscriber's Social Security No.	Subscriber's Date of Birth (DD/MM/YYYY)

Subscriber Phone No.	Relationship to Subscriber
( ) -	○ Self ○ Spouse ○ Child ○ Other

Secondary Insurance	Policy Number	Plan/Group Number

Subscriber's Name	Subscriber's Social Security No.	Subscriber's Date of Birth (DD/MM/YYYY)

Subscriber Phone No.	Patient's Relationship to Subscriber
( ) -	○ Self ○ Spouse ○ Child ○ Other

IN CASE OF EMERGENCY

Name	Relationship to Patient	Cell/Home Phone No.	Work Phone No.
		( ) -	( ) -

Emergency Contact Address	City	State	ZIP Code

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cancer Center at Gaithersburg or insurance company to release any information required to process my claims. My permission is given to use a copy of this authorization in place of the original. This authorization may be revoked by either myself or Cancer Center at Gaithersburg at any time, provided it is done in writing. I understand this is a LIFETIME AUTHORIZATION and can only be revoked by myself or Cancer Center at Gaithersburg in writing. I understand and agree that should my account be turned over to a collection agency and/or attorney, all fees incurred will become my responsibility and be added to my principal balance.

X

Patient/Guardian Signature	Date

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