

**Patient Registration Form**

**Site Address:**

**Phone:**

**Fax:**

*Welcome to our office.* Please help us complete your record by furnishing the information below. If you have any questions regarding your care or your appointments, please feel free to discuss any of these matters with us. *Thank you.*

**PERSONAL INFORMATION**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_ WORK PHONE # \_\_\_\_\_  
\_\_\_\_\_

**IN CASE OF EMERGENCY PLEASE NOTIFY:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ HOME: \_\_\_\_\_  
CELL: \_\_\_\_\_  
WORK: \_\_\_\_\_

**NAME OF RELATIVE/FRIEND WHO DOES NOT LIVE IN YOUR HOME:**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ HOME: \_\_\_\_\_  
CELL: \_\_\_\_\_  
WORK: \_\_\_\_\_

**REFERRING PHYSICIANS**

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

REFERRING PHYSICIAN: (if different from PCP) \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_

OTHER PHYSICIANS YOU WISH TO RECEIVE REPORTS: \_\_\_\_\_

**PHARMACY INFORMATION**

PHARMACY NAME: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

**INSURANCE INFORMATION**

Are you currently insured?  YES  NO

If NO: Have you or do you plan to apply for COBRA?  YES  NO

INSURANCE CO. #1: \_\_\_\_\_

INSURANCE #1: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ SEX: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

INSURANCE CO. #2: \_\_\_\_\_

INSURANCE #2: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

INSURANCE CO. #3: \_\_\_\_\_

INSURANCE #3: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

I hereby authorize and direct you to pay Commonwealth Hematology-Oncology, P.C. benefits due me out of indemnity under the terms of my policy issued by my insurance company. I authorize the release of medical information necessary to process this claim and request payment of Medicare benefits either to myself or the party who accepts assignment. I am also responsible for any services provided for which I did not obtain a referral from my primary care physician. I understand that I am responsible for all copayments and deductible payments not otherwise covered by my insurance plan.

PATIENT'S SIGNATURE: x \_\_\_\_\_ DATE: \_\_\_\_\_

or AUTHORIZED PERSON'S SIGNATURE: x \_\_\_\_\_