

THE CENTER FOR CANCER & BLOOD DISORDERS

PATIENT REGISTRATION FORM

- | | |
|------------------------------------|--|
| <input type="checkbox"/> ARLINGTON | <input type="checkbox"/> MAGNOLIA |
| <input type="checkbox"/> CLEBURNE | <input type="checkbox"/> MINERAL WELLS |
| <input type="checkbox"/> DENTON | <input type="checkbox"/> STEPHENVILLE |
| <input type="checkbox"/> GRANBURY | <input type="checkbox"/> SOUTHWEST |
| <input type="checkbox"/> HUGULEY | <input type="checkbox"/> WEATHERFORD |

- | | | |
|--|--|--|
| <input type="checkbox"/> MATTHEW CAVEY, M.D. | <input type="checkbox"/> PETER LANASA, M.D. | <input type="checkbox"/> BIBAS REDDY, D.O. |
| <input type="checkbox"/> GREGORY FRIESS, D.O. | <input type="checkbox"/> LANCE MANDELL, M.D. | <input type="checkbox"/> MICHAEL ROSS, M.D. |
| <input type="checkbox"/> PRASANTHI GANESA, M.D. | <input type="checkbox"/> SHADAN MANSOOR, M.D. | <input type="checkbox"/> MARY ANN SKIBA, D.O. |
| <input type="checkbox"/> GUS GONZALEZ, M.D. | <input type="checkbox"/> ANN-MARGARET OCHS, D.O. | <input type="checkbox"/> DE ETTÉ VASQUES, D.O. |
| <input type="checkbox"/> J. CARLOS HERNANDEZ, M.D. | <input type="checkbox"/> RAY PAGE, D.O. | <input type="checkbox"/> HENRY XIONG, M.D. |
| <input type="checkbox"/> NATHAN KIM, M.D. | <input type="checkbox"/> VINAYA POTLURI, M.D. | <input type="checkbox"/> ROBYN YOUNG, M.D. |

ACCT# _____ **DATE:** _____ **TIME:** _____

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION	
Name: _____	
Last	First
Address: _____	
City: _____	State _____ Zip _____
Home Phone: _____ Date of Birth: _____	
Cell Phone: _____	
Social Security #: _____	
E-mail address: _____	
Employer: _____	
Work Phone: _____	
Retired? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, from where? _____	
Marital Status: Single, Married, Divorced, Common Law, Life Partner, Legally Separated	

PRIMARY INSURANCE INFORMATION	
<input type="checkbox"/> Group	<input type="checkbox"/> Individual
INSURANCE NAME: _____	
ID#: _____	
GROUP#: _____	
INSURANCE TELEPHONE #: _____	
WHOSE EMPLOYER IS INSURANCE THROUGH?	
PATIENT OR SPOUSE ? (circle one)	
Referral Required <input type="checkbox"/> Yes <input type="checkbox"/> No Received <input type="checkbox"/> Yes <input type="checkbox"/> No	

SPOUSE/ POLICYHOLDER INFORMATION	
Name of Spouse: _____	
Date of Birth: _____	
Social Security #: _____	
Retired? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, from where? _____	
Employer: _____	
Work Phone #: _____	

SECONDARY INSURANCE INFORMATION	
<input type="checkbox"/> Individual	<input type="checkbox"/> Group
INSURANCE NAME: _____	
ID#: _____	
GROUP#: _____	
INSURANCE TELEPHONE #: _____	
WHOSE EMPLOYER IS INSURANCE THROUGH?	
SPOUSE OR PATIENT ? (circle one)	
Referral Required <input type="checkbox"/> Yes <input type="checkbox"/> No Received <input type="checkbox"/> Yes <input type="checkbox"/> No	

PRIMARY CARE PHYSICIAN*	
Name: _____	
Phone# _____	
Pharmacy Name: _____	
Pharmacy Phone# _____	

EMERGENCY CONTACT	
Name: _____	
Relationship: _____	
Home Phone# _____	
Cell Phone# _____	
<input type="checkbox"/> No Emergency Contact	

To Whom May We Release Information and Records Regarding Your Care?	
1. _____	Relationship: _____
2. _____	Relationship: _____

AS A COURTESY TO OUR PATIENTS, WE WILL FILE WITH YOUR INSURANCE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM. I HEREBY AUTHORIZE PAYMENTS DIRECTLY TO UNDERSIGNED PHYSICIAN(S) FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO FOR HIS/HER SERVICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE: _____ **SIGNATURE OF INSURED:** _____

FOR OFFICE USE ONLY	
Referred By: _____	Reason for Visit: _____
Phone# _____ Fax# _____	Spoke with: _____
NPI# _____	Records Requested: _____

FORM VERIFIED AND OBTAINED BY: _____ **DATE:** _____