



THE AUSTIN CENTER
FOR
RADIATION ONCOLOGY

1020 West 34th Street

PATIENT REGISTRATION FORM

TODAY'S DATE: _____/_____/_____

REFERRING UROLOGIST _____ PRIMARY CARE DR _____

PATIENT NAME _____
LAST FIRST M.I.

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

EMAIL ADDRESS _____

DATE OF BIRTH _____/_____/_____ AGE _____ S.S.# _____-_____-_____

DRIVER'S LICENSE # _____/STATE _____ SEX: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYMENT STATUS: EMPLOYED SELF-EMPLOYED RETIRED OTHER

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP TO PATIENT _____

PHONE # _____ ALTERNATE # _____

INSURANCE INFORMATION

DO YOU HAVE PRIVATE INSURANCE? YES NO

DO YOU HAVE MEDICARE? YES NO

DO YOU HAVE A MEDICARE SUPPLEMENT OR SECONDARY INSURANCE? YES NO

MEDICARE INSURANCE INFORMATION (IF APPLICABLE)

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

INSURED DATE OF BIRTH (DOB): _____/_____/_____ INSURED S.S.# _____-_____-_____

MEDICARE ID#: _____ EFFECTIVE DATE: _____/_____/_____

PRIMARY INSURANCE INFORMATION –IF YOU HAVE A MEDICARE REPLACEMENT POLICY PLEASE FILL OUT THIS SECTION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

INSURED DATE OF BIRTH (DOB): _____/_____/_____ INSURED S.S.# _____-_____-_____

INSURED EMPLOYEE NAME (IF APPLICABLE) _____ PHONE _____

INSURED COMPANY NAME _____ EFFECTIVE DATE _____

POLICY/ID #: _____ GROUP #: _____ COPAY: _____

SECONDARY/MEDICARE SUPPLEMENT INSURANCE INFORMATION (IF APPLICABLE)

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

INSURED DATE OF BIRTH (DOB): _____/_____/_____ INSURED S.S.# _____-_____-_____

INSURED EMPLOYEE NAME (IF APPLICABLE) _____ PHONE _____

INSURED COMPANY NAME _____ EFFECTIVE DATE _____

POLICY/ID #: _____ GROUP #: _____ COPAY: _____

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED AT THE AUSTIN CENTER FOR RADIATION ONCOLOGY. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO BE PAID TO THE PHYSICIAN. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I HAVE READ AND CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE STAFF OF ANY CHANGES IN MY HEALTH STATUS OR ANY CHANGES IN THE ABOVE INFORMATION.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____/_____/_____
DATE SIGNED