Carolina Oncology Specialists

# PATIENT REGISTRATION FORM

| Last | First | Middle | Maiden | Female ☐ Male ☐ |
|---|---|---|---|---|
| | | | | |

| Birthdate / / | Age | SS# - - | Race | Marital Status |
|---|---|---|---|---|
| | | | | |

| Mailing Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone # ( ) - | Cell Phone# ( ) - | Work Phone# ( ) - |
|---|---|---|
| | | |

| Email | Employer Name/Address |
|---|---|
| | |

| Spouse's Name | Spouse's Birthdate / / | Spouse's SS# - - |
|---|---|---|
| | | |

## *Primary Insurance*

Insurance Company & Address

| Policy # | Group # |
|---|---|
| | |

| Policy Holder Name | Birthdate / / | SS# - - | Relation |
|---|---|---|---|
| | | | |

## *Secondary Insurance*

Insurance Company & Address

| Policy # | Group # |
|---|---|
| | |

| Policy Holder Name | Birthdate / / | SS # - - | Relation |
|---|---|---|---|
| | | | |

## *Authorizations and Consent*

***Authorization to pay benefits to the physician***: I hereby authorize payment directly to Carolina Oncology Specialists, P.A. for any services furnished to me by this provider. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid to me.

***Person responsible for payment if patient is unable:***

| Name | Relation | Phone # |
|---|---|---|
| | | |

***Consent for purposes of treatment, payment and healthcare operations:*** I hereby consent to treatment by Carolina Oncology Specialists, P.A. . I also consent to the use or disclosure of my protected health information by COS for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of COS. I understand that diagnosis and/or treatment may be conditional upon my consent.

***Acknowledgement of Receipt of Notice of Privacy Practices:*** I have received a copy of Notice of Privacy Practices.

****Patient Signature:*** ***Date:***