



REGISTRATION FORM

Today's date:				Primary Care Physician:			
PATIENT INFORMATION							
Patient's last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
						Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Email:				Race:			
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other	
Other family members seen here:							
Smoking :	yes	no	How much:	occasionally	1 pack	2 packs	more
Pharmacy Name:		Pharmacy Address:			Pharmacy phone no.: ()		

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:			Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Aetna	<input type="checkbox"/> BCBS		<input type="checkbox"/> Cigna	<input type="checkbox"/> Coventry	<input type="checkbox"/> Humana
<input type="checkbox"/> UHC	<input type="checkbox"/> Medicaid		<input type="checkbox"/> Medicare	<input type="checkbox"/> Welfare (Please provide coupon)		<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Personalized Hematology-Oncology of Wake Forest, PLLC or insurance company to release any information required to process my claims.</p>			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	