Fairbanks Cancer Care Physicians, P.C.

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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name	First	MI	Female ☐ Male ☐	Birth Date	Age	SS#

Mailing Address	Apt#	City	State	Zip

Physical Address (If different than mailing)	Apt#	City	State	Zip

Marital Status	Home #	Cell #	Work #	Messages OK? Yes ☐ No ☐

Referred By:	Primary Dr:

Employer Name/Address	City	State	Zip	Occupation

Emergency Contact	Relationship	Phone #

INSURANCE

Primary Insurance - Name & Address

Policy #	Group #	Effective Date

Policy Holder Name	DOB	SS#	Relationship To Patient

Secondary Insurance - Name & Address

Policy #	Group #	Effective Date

Policy Holder Name	DOB	SS#	Relationship To Patient

Tertiary Insurance - Name & Address

Policy #	Group #	Effective Date

Policy Holder Name	DOB	SS#	Relationship To Patient

Please complete if patient is a minor or a student:

MINOR

Mother's Name:	DOB:	SSN:

Address:	Home Phone:

Employer:	Work Phone:

Father's Name:	DOB:	SSN:

Address:	Home Phone:

Employer:	Work Phone:

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

ASSIGNMENT OF BENEFITS: I hereby assign or transfer payment benefits made to me and my behalf to Fairbanks Cancer Care Physicians, P.C. for any services furnished to me by this physician/supplier. 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 me.

RELEASE OF INFORMATION: I hereby authorize Fairbanks Cancer Care Physicians, P.C. to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits related payable for related charges.

Patient Signature	**Spouse Signature or responsible party (must be signed if applicable)**	**Date**