THE START CENTER FOR CANCER CARE

Patient ID: | Patient Name: First Middle Last Sex

Address: Street

City State Zip County

Home Phone: Work Phone: Cell Phone:

Date of Birth: Age: SSN:

Language: Race: Ethnicity:

Marital Status: Employer:

Spouse Name: Spouse SSN: Spouse DOB:

Emergency Contact: (not residing with you) Name Relationship Phone

Doctor: Doctor Ph: Doctor Fax:

Referring MD: Ref MD Ph: Ref MD Fax:

PCP: PCP Ph: PCP Fax:

Primary Ins: ID: Group #:

Policy Holder: Birthdate:

Relationship:

Secondary Ins: ID: Group #:

Policy Holder: Birthdate:

Relationship:

Did you make any changes to the above information? (please circle one) YES NO

What changed?

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian Printed Name Date

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian Printed Name Date