START CENTER FOR CANCER CARE
A Partner of OneOncology

Patient Demographic and Registration Form

Please print clearly in blue or black ink, or complete this form on screen.

FRM-REG-DEMO-001 Rev. 2.0

SECTION A. PATIENT INFORMATION

Last Name	First Name	Middle Initial	Date of Registration (DD/MM/YYYY)

Preferred Name	Former or Maiden Name	Date of Birth (DD/MM/YYYY)	Social Security Number

Street Address	Apartment or Unit	County

City	State	ZIP Code	Mailing Address (if different)

Home Phone	Cell Phone	Work Phone	Email Address

Preferred Method of Contact	Marital Status	Preferred Written and Spoken Language

Interpreter Services Needed	Employment Status	Employer Name	Employer Phone

SECTION B. RACE, ETHNICITY AND SEX

Race and ethnicity are collected for public health reporting to the Texas Cancer Registry (Texas Health and Safety Code Chapter 82) and for quality reporting. They are never used to determine your eligibility for care. You may decline any item in this section.

Race	Ethnicity

Biological Sex	Veteran or Active Military	Religious Preference (optional)

SECTION C. FINANCIALLY RESPONSIBLE PARTY / GUARANTOR

Is the patient the responsible party / guarantor? If Yes, skip to Section D.	Relationship to Patient

Guarantor Last Name	First Name	MI	Date of Birth (DD/MM/YYYY)

Street Address	City	State	ZIP Code

Home Phone	Cell Phone	Work Phone	Email Address

Occupation	Employer	Employer Phone

SECTION D. EMERGENCY CONTACTS, LEGAL REPRESENTATIVE AND ADVANCE DIRECTIVES

Primary Emergency Contact Name	Relationship	Primary Phone	Alternate Phone

Secondary Emergency Contact Name	Relationship	Primary Phone	Alternate Phone

Do you have a legal guardian, medical power of attorney, or other personal representative?	Representative Name	Representative Phone

This completed form contains protected health information. Handle, store, and dispose of it in accordance with START Center for Cancer Care policy, the HIPAA Privacy and Security Rules, and the Texas Medical Records Privacy Act (Texas Health and Safety Code Chapter 181).

SECTION E. COMMUNICATION PREFERENCES AND PERSONS AUTHORIZED TO RECEIVE INFORMATION

START may share your health information with family or others involved in your care as permitted by 45 CFR 164.510(b). List below anyone we may speak with and what they may be told. You may add, change, or remove a name at any time by notifying the Privacy Officer in writing.

May we leave a detailed message on your voicemail?	May we leave a message with a household member?	May we mail correspondence to the address above?

I consent to receive appointment and care text messages at the cell number above	I consent to receive email from START at the address above

Authorized Person 1 - Name	Relationship	Phone	Information They May Receive

Authorized Person 2 - Name	Relationship	Phone	Information They May Receive

SECTION F. REFERRING PROVIDER, PRIMARY CARE PROVIDER AND PHARMACY

Referring Physician Name	Practice or Facility	Phone	Fax

Primary Care Physician Name	Practice or Facility	Phone	Fax

☐ Same as referring physician above

How did you hear about START?	If Other, please describe

Preferred Pharmacy Name	Pharmacy Address or Cross Streets	Pharmacy Phone

SECTION G. PRIMARY INSURANCE

Primary Insurance Company	Plan Name or Product	Payer Phone

Policy or Member ID Number	Group Number	Coverage Effective Date (DD/MM/YYYY)	Patient Relationship to Insured

Subscriber Name (if not the patient)	Subscriber DOB (DD/MM/YYYY)	Subscriber Sex	Subscriber SSN

Subscriber Employer	Subscriber Work Phone	Was a copy of the card presented?

SECTION H. SECONDARY INSURANCE

Secondary Insurance Company	Plan Name or Product	Payer Phone

Policy or Member ID Number	Group Number	Coverage Effective Date (DD/MM/YYYY)	Patient Relationship to Insured

Subscriber Name (if not the patient)	Subscriber DOB (DD/MM/YYYY)	Subscriber Sex	Subscriber SSN

Subscriber Employer	Subscriber Work Phone	Was a copy of the card presented?

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SECTION I. OTHER COVERAGE AND LIABILITY INFORMATION

Are you enrolled in Medicare?	Medicare Beneficiary Identifier (MBI)	Are you enrolled in Medicaid?

Do you have no health insurance and wish to be seen as self-pay?

SECTION J. PATIENT ACKNOWLEDGMENTS AND SIGNATURE

1. Accuracy of Information. I certify that the information on this form is true and correct to the best of my knowledge. I will notify START Center for Cancer Care promptly of any change to my address, telephone number, insurance coverage, or responsible party.

2. Use and Disclosure for Treatment, Payment and Health Care Operations. I understand that START may use and disclose my protected health information for treatment, payment, and health care operations without my written authorization, as permitted by 45 CFR 164.506. This includes releasing information to my insurance carriers, other treating providers, and health care facilities as needed to obtain payment and coordinate my care. Disclosures to my employer, or for marketing or the sale of my information, require a separate written authorization that I may revoke at any time.

3. Assignment of Benefits and Financial Responsibility. I assign to START Center for Cancer Care all benefits payable for services rendered and authorize direct payment to START. I understand that I am financially responsible for any charge not covered by my insurance, including charges denied because eligibility could not be verified, and for applicable copayments, coinsurance, and deductibles.

4. Notice of Privacy Practices. I acknowledge that I have been offered a copy of the START Center for Cancer Care Notice of Privacy Practices, as required by 45 CFR 164.520(c)(2).

Patient or Legal Representative Signature	Printed Name	Date (DD/MM/YYYY)
Wet signature		
Guarantor Signature (if different from patient)	**Printed Name**	**Date (DD/MM/YYYY)**
Wet signature		

If signed by a personal representative, describe legal authority to act for the patient	Documentation Verified By (staff initials)

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