Oregon Oncology Specialists

Acct. #_____ Date: _____

# Patient Registration Form

Welcome to our office. In order to serve you properly, we will need the following information. All information will be strictly confidential. (Please Print)

| Patient's Name (Last, First, MI) | Sex ❑ M ❑ F | Birthdate ___/___/___ | Age | Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced |
|---|---|---|---|---|
| Mailing Address | City | State | Zip | |
| Street Address | City | State | Zip | |

| Home Phone: ( ) - | Cell Phone: ( ) - | Email: | Patient's Social Security # - - |
|---|---|---|---|

| Patient's Employer Address | Work Phone # ( ) - | Occupation |
|---|---|---|

| Name of Spouse | Spouse Work Phone # ( ) - | Spouse Cell Phone # ( ) - |
|---|---|---|

| Person to contact in case of emergency | Relationship to patient | Phone # ( ) - |
|---|---|---|

| Person financially responsible for this account | ❑ Self ❑ Spouse ❑ Parent | Responsible party's date of birth | Social Security # - - |
|---|---|---|---|

| Referring Physician | Primary Care Physician | Are you currently enrolled in hospice? ❑ Yes ❑ No | Are you currently living in a skilled nursing facility? ❑ Yes ❑ No ❑ If yes, where? |
|---|---|---|---|

| Primary Insurance Company Address | | | Is insurance through your employer? ❑ Yes ❑ No |
|---|---|---|---|
| Subscriber Name | Subscriber Birth Date / / | Policy # | Group # |
| Secondary Insurance Company Address | | | |
| Subscriber Name | Subscriber Birth Date / / | Policy # | Group # |

**Please read and sign below.**

I hereby authorize doctors of Oregon Oncology Specialists, LLP to furnish the patient's insurance company all information which said insurance company may request. This authorization shall continue and be in force and effect until revoked in writing by me. I hereby assign to the doctors of Oregon Oncology Specialists, LLP, all money to which I am entitled for medical expense relative to the services performed from time to time, but not to exceed my indebtedness to said physicians. It is understood that any money received from the insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctors for charges not covered by insurance. Any funds I receive from an insurance company, Medicare or Medicaid for services rendered to me by Oregon Oncology Specialists, LLP shall be immediately paid over to Oregon Oncology Specialists, LLP. Regardless of insurance payments, the patient or guardian is personally responsible for payment of all charges for services provided by Oregon Oncology Specialists, LLP. Any sums unreimbursed by insurance, Medicare or Medicaid are due and payable within 30 days of invoicing. Any sums not timely paid shall bear interest at the rate of 10% per annum until paid. if Oregon Oncology Specialists, LLP hires an attorney to collect any past due sums, the patient and/or guardian/parent shall pay Oregon Oncology Specialists costs, disbursements and reasonable attorney's fees incurred in its collection effort, including in trial or on appeal.

Date:___/___/___ _____ _____

PRINT PATIENT NAME PRINT PARENT OR GUARDIAN'S NAME

_____ _____

PATIENT SIGNATURE PARENT or GUARDIAN'S SIGNATURE