VENTURA COUNTY HEMATOLOGY ONCOLOGY SPECIALISTS

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Family Name: First: Middle:	Marital status: ❑Single ❑Married ❑Divorced ❑ Separated ❑Widowed ❑Life Partner	Sex: ❑ M ❑ F

Former Name (if applicable):	Birth Date:	Social Security No. :	Race: ❑ American Indian or Alaska Native ❑Asian ❑Black or African American ❑White ❑Native Hawaiian or Other Pacific islander ❑Mixed	Ethnicity: ❑ Hispanic or Latino ❑Not Hispanic or Latino

Home Address: Street	Home Phone: ( )	Cell Phone: ( )

City : State: Zip Code:	Email Address:	Preferred Language: ❑ English ❑ Other ❑ Spanish ______________

Mailing Address (if different from above)

Occupation:	Employer Name and Address:	Work Phone ( )

Referring Physician's Name and Phone :	Primary Physician's Name and Phone:

Emergency Contact Name and Address:	Relationship to Patient:	Home Phone : ( )	Cell Phone: ( )	Work Phone : ( )

RESPONSIBLE PARTY INFORMATION

Person Responsible for Bill:	Relationship to Patient:	Physical Address (if different from patient's):

Birth Date:	Social Security No. :	Email Address:

Employer Name and Address:	Work Phone ( )	Home Phone : ( )	Cell Phone: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Primary Insurance:	Address:		Group No.:	Policy No.:	Co-payment:
Subscriber's name:	Subscriber's S.S. No.:	Birth Date:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of Secondary Insurance:	Address:		Group No.:	Policy No.:	Co-payment:
Subscriber's name:	Subscriber's S.S. No.:	Birth Date:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		

AUTHORIZATION AND ACCEPTANCE OF RESPONSIBILITY

The above information is true to the best of my knowledge. I understand it is my responsibility to pay any deductible, coinsurance or balance not paid by my insurance. I authorize my insurance benefits be paid directly to the treating physician. I authorize release of my medical records to other facilities as deemed appropriate and to my insurance when required to process my claims.

______________________________ ______________________________

Patient or Guardian (if Minor) Signature Date