PATIENT REGISTRATION FORM

Patient Name:_____ DOB: _____

Marital Status: Single / Married / Divorced / Widowed SSN: _____ Sex: M / F

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone Numbers: Home:_____ Work: _____ Cell:_____

Email:_____ Place of Birth:_____

Race:_____ Religion:_____ Ethnicity:_____ Language:_____

Temporary Address, if applicable

Street Address:_____

City:_____ State:_____ Zip Code:_____

Referred by:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Spouse's Name:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Diagnosis/reason for visit:_____

_____

Patient Employer Name:_____ Phone: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Occupation/Title:_____

Insured Persons Information (if not the patient)

Name:_____ Phone:_____

Street Address:_____

Cassidy Cancer Center
200 Avenue F NE ▪ Winter Haven, FL ▪ 33881
Phone: 863.292.4670 ▪ Fax: 863.292.4671

City:_____ State:_____ Zip Code:_____

Relationship to patient:_____ DOB:_____ SSN:_____

Employer Name:_____ Phone:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Insurance Information

Primary Insurance Company Name:_____

Member ID:_____ Group ID:_____ Phone: _____

Secondary Insurance Company Name:_____

Member ID:_____ Group ID:_____ Phone: _____

Pharmacy Information:

Name:_____ Phone:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

HIPAA Authorizations

Person(s) who is authorized to access your medical records:

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Person(s) who is authorized to access your financial / billing records:

Contact: _____ Phone: _____

Contact: _____ Phone: _____

Authorization to leave messages on home and/or cell phone:

Home Phone: _____

Cell Phone: _____

Signature for HIPAA Authorizations: _____

Date: _____

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Advance Directives

Do you currently have any of the following directives?

- ☐ Health Care Durable Power of Attorney
- ☐ Organ Donor
- ☐ Autopsy Request
- ☐ Living Will / Personal Directive
- ☐ Do Not Hospitalize Status
- ☐ Do Not Resuscitate Status
- ☐ Feed Restrictions
- ☐ Medication Restrictions
- ☐ Other Treatment Restrictions

If you have any of these directives, please bring a copy with you so we can store them with your records.

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