EJGH Radiation Oncology

PATIENT REGISTRATION

Today's Date: _____ MR # _____

PATIENT: *(Please Print)* Date of Birth: _____

Patient Name: _____ Social Security Number: _____
Last First Middle Initial

Address: _____ Home Phone Number :( )_____
Apartment Number/ Street Address

City/State/Zip:_____ Cell Phone Number:( )_____

Mailing Address (if not above): _____ Email Address: _____

Employer: _____ Work Phone Number :( )_____

Sex: ☐Male ☐ Female Preferred Contact Number (circle): Cell Home Work

If you do not wish to provide your race and/or ethnicity, please select Decline.

Race: ☐White ☐African American/Black ☐Native Hawaiian/Pacific Islander ☐Hispanic ☐Native American ☐Other ☐Decline

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other ☐Decline

Preferred Language:_____

Marital Status: ☐ Single ☐ Married ☐ other: _____ Spouse's Name_____

Spouse's Social Security Number:_____ Spouse's Date of Birth: _____

Employment Status: ☐ Employed ☐ Retired

Chosen Physician within this Practice: Dr. Monsour Dr. Padmanabha

Referral Physician Name _____ Diagnosis:_____

Primary Care Physician: _____

Emergency Contact: _____( )_____
Name Relationship Phone Number

Preferred Pharmacy: _____
Name Address Phone Number

GUARANTOR

Person Responsible for Payment: Name (If not above): _____ ☐ Patient ☐ Spouse ☐ Parent/Guardian ☐ Other

Address (if not above):_____Social Security Number: _____

Phone Number (if not above): Home:( )_____ Work:( )_____

List those we can speak with regarding your health:_____

_____

_____ _____

Signature of Patient or Legal Representative *(Parent/Guardian/Power of Attorney)* Date

WOULD YOU LIKE A COPY OF OUR PRIVACY NOTICE? ☐ Yes ☐ No