Attending Physician ____________________ Patient number ____________________

Cancer Care Center of Jackson

322 Hospital Blvd, Jackson, TN 38305

Phone: (731) 668-1668 **PATIENT REGISTRATION** Fax: (731) 668-5801

Patient Name: ______________________________ **SSN:** ______________
Last First MI

Address: ____
Street City State Zip

Home phone: ______________ **Cell phone:** ______________ **E-mail Address:** ______________

Date of Birth: ______________ **Age:** ________ **Sex:** M F **Marital Status:** S M D W

Race: Black Latino Oriental White Other **Ethnicity:** African American Asian Caucasian Chinese Latino Native American Other

Preferred Language: ______________ **Contact Preference:** cell phone E-mail home phone mail

Patient Employer: ______________________________ **Phone:** ______________

Spouse: ______________ **SS#:** ______________ **DOB:** ______________

Spouse Employer: ______________________________ **Phone:** ______________

Emergency contact: ______________ **Relationship:** ______________ **Phone:** ______________

Referring Physician: ______________ **Primary Care Physician:** ______________

Have you ever had **radiation treatment**? Y N Where? ______________ Physician: ______________

Have you ever had **chemotherapy**? Y N Where? ______________ Physician: ______________

PHARMACY ______________________________ **PHONE NUMBER** ______________

INSURANCE INFORMATION

Primary Insurance: ______________________________ **Insured's name:** ______________

Secondary Insurance: ______________________________ **Insured's name:** ______________

CANCER INSURANCE POLICY? YES________ NO ________ NAME OF INSURANCE: ______________

I attest that I have informed Cancer Care Center of all insurance policies and understand it is my responsibility to inform Cancer Care Center of any change of insurance. Please indicate you understand by initialing ________

DO YOU HAVE A LIVING WILL AND / OR ADVANCED DIRECTIVE? Y N COPY ON FILE Y N

RELEASE OF INFORMATION AND INSURANCE

I agree and authorize medical treatment as deemed necessary by the Cancer Care Center of Jackson to furnish information concerning any treatment to insurance companies, financial information as deemed necessary , and I hereby irrevocably assign to the Cancer Care Center of Jackson all insurance benefits payable to me by my insurance company and/or my cancer policy, not to exceed the charges shown. **If my cancer policy will not reimburse directly to Cancer Care Center, I understand it will be my responsibility to reimburse Cancer Care Center upon receipt of monies, from my cancer policy, paid to me for insurance claims owed to Cancer Care Center for treatment received.** I understand that I am financially responsible for any amounts that are not covered by my insurance and that the Cancer Care Center of Jackson can not accept responsibility for collection insurance claims or for negotiating a settlement on a disputed claim. I understand that I am responsible for my account. The undersigned further agrees that in the event his/her account is turned over to an attorney; the undersigned shall be responsible for all cost of collection, including out of pocket expenses, court costs and attorney fees. I request that payment of authorized Medicare benefits be made on my behalf to Cancer Care Center of Jackson for any service furnished to me by that clinic. I authorize any holder of medical information about me, to be released to the CMS and its agents. I also authorize the release of any information needed to determine these benefits payable for related services.
I agree and authorize necessary medical/financial information contained in my health records to be released to the Cancer Care Center, including history and physical, progress notes, pathology, lab, and X-ray reports for the purpose of radiation and/or chemotherapy. I give permission for Cancer Care Center physicians and staff to view my prescription history and to transmit prescriptions electronically. This agreement shall be valid for one year from the date of signature.

______________________________ ______________
Signature of patient or legal guardian Date

______________________________ ______________
Signature of patient or legal guardian---no change for above information Date

______________________________ ______________
Signature of patient or legal guardian---no change for above information Date