Lancaster Cancer Center
Care Beyond Treatment

Lancaster Cancer Center
PATIENT REGISTRATION

Print Form

Personal Information:

Name: _____ **Marital Status:** ☐ S ☐ M ☐ W ☐ D **(check one)**

Address: _____ **Home #:** _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Social Security #:** _____

Cell #: _____ **Work #:** _____

Employer: _____ **Occupation:** _____

Employer Address: _____ **Phone #:** _____

Spouse Name: _____ **DOB:** _____ **SSN #:** _____

Spouse Employer: _____ **Occupation:** _____

Employer Address: _____ **Phone #:** _____

Family Physician: _____ **Phone #:** _____

Referring Physician: _____ **Phone #:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

In Case of Emergency:

Contact: _____ **Phone #:** _____ **Relationship:** _____

Contact: _____ **Phone #:** _____ **Relationship:** _____

I hereby authorize Lancaster Cancer Center to release any information acquired in the course of my examination or treatment for insurance claims, and authorize payment directly to Lancaster Cancer Center, or any medical benefits, otherwise payable to me for their services. I understand I am financially responsible for all charges not covered by this authorization and guarantee payment of this account. This authorization is valid until further notice.

Patient Signature: _____ **Date:** _____