Lancaster
Cancer Center
Care Beyond Treatment

Patient Registration

Name: ____________________________________

DOB: _____________________________________

Social Security #: ___________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: __________________________________

____

Home Phone #: ______________________________

Cell Phone #: _______________________________

Employed: ☐ Retired ☐ Unemployed ☐ Disabled ☐ Homemaker

Employer's Name: ___________________________

Occupation: _______________________________

Address: __________________________________

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Phone #: __________________________________

Spouse's Name: _____________________________

Spouse's DOB: ______________________________

Phone #: __________________________________

Race: ☐ Caucasian ☐ African American ☐ Chinese ☐ Native American ☐ Japanese ☐ Asian ☐ Multiracial ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Declined ☐ Not Hispanic/Latino

Birthplace:

City: _______________________________

State: ______________________________

Email Address: ______________________________

Do you want to sign up for our patient portal?

☐ Yes ☐ No

How did you hear about us?

☐ Patient ☐ Family/Friend ☐ Physician ☐ Internet ☐ Other: __________

Primary Insurance: ___________________________

ID #: _______________________________

Secondary Insurance: _________________________

ID #: _______________________________

Family Physician: ____________________________

Phone #: ___________________________________

In Case of Emergency:

Contact: ____________________________ Relationship: _____________________ Phone #: _______________

Contact: ____________________________ Relationship: _____________________ Phone #: _______________

I hereby authorize Lancaster Cancer Center, LTD to release any information acquired in the course of my examination or treatment for insurance claims, and authorize payment directly to Lancaster Cancer Center, LTD, of any medical benefits, otherwise payable to me for their services. I understand that 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: _______________________________