PATIENT REGISTRATION
Dr. Mohtaseb Cancer Center and Blood Disorders

PATIENT INFORMATION		
Gender:	Marital Status:	Date of Birth: Age:
Last Name:		Social Security #:
First Name: Middle Initial:		Home Phone:
Address:		Cell Phone:
City, State, Zip:		Work Phone:
Employer:		Email address:
COORDINATION OF CARE INFORMATION		**EMERGENCY CONTACT INFORMATION**
Primary Care Provider:		**Name:**
Phone:		Relationship:
Preferred Lab:		Contact Phone:
Preferred Pharmacy:		**Name:**
		Relationship:
		Contact Phone:

INSURANCE INFORMATION		
Primary Insurance:		Insured Policy ID:
Second Insurance:		Insured Policy ID:
Third Insurance:		Insured Policy ID:

ADVANCE DIRECTIVE		
Do you have a Living Will?	**Yes / No**	Are you interested in more information? **Yes / No**
Do you have a Durable Power of Attorney?	**Yes / No**	Are you interested in more information? **Yes / No**
Do you have a DNR?	**Yes / No**	Are you interested in more information? **Yes / No**
(Do not resuscitate)		

OPTIONAL INFORMATION

How would you prefer to be contacted: [] Letter [] Email [] Phone [] Phone – no voicemail [] No reminders

How did you hear about our office? [] Radio [] Newspaper article/ad [] Medical provider [] Friend/Family [] Other

Race: America Indian, Asian, Black, Caucasian, Hispanic, Native Hawaiian, Other Pacific Islander, Other:

Ethnicity: Hispanic / Not Hispanic

Preferred Language: English, Spanish, French, Italian, Japanese, Russian, Other:

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize this office to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges., I hereby authorize this practice to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. If at any time it becomes necessary to assign your outstanding balance due to an outside collection agency or attorney for collection of monies owe to this practice, you the patient/guarantor agree to, in addition to the principal balance owed, pay all related collection and/or legal costs and fees. This authorization shall continue and be in full force and effect until revoked in writing by me. I acknowledge receipt of the *NOTICE OF PRIVACY PRACTICE*

X_____ **Date:**_____

Signature