CAROLINA SURGERY & CANCER CENTER, PLLC

advanced personal care close to home

PATIENT REGISTRATION

CAROLINA SURGERY & CANCER CENTER - 1501 TATE BLVD SE, SUITE 202 - HICKORY, NC
TELEPHONE 828-485-2707 FAX 828-485-2708

Patient's Account Number: _____ Today's Date: _____
Patient's SS #: _____ Referring Physician / Family Doctor: _____
Patient's Name: _____
Patient's Address: _____
City, State and ZIP: _____
Patient's Home Phone: _____ Patient's Cell Phone: _____
Patient's Birth Date: (month/day/year) _____ Patient's Age: _____
Patient's Email Address: _____
Marital Status (Circle One): Single / Married / Divorced / Widowed Patient's Sex, Circle one: Male / Female
Pharmacy: _____
Emergency Contact: _____ Phone Number: _____
Relationship to Patient: _____

Person Financially Responsible: Primary Policy Holder / Self / Spouse / Parent

Responsible Party's Name _____ Responsible Party's SSN#: _____
Responsible Party's Phone Number _____ Responsible Party's Birth Date: _____

Name of Employer: _____
Employer's Phone Number: _____
Name of Insurance Company: _____
Workers' Compensation: Yes ( ) Motor Vehicle Accident: Yes ( ) Date of Accident: _____
Treatment authorized by: _____ Claim #: _____
If Yes-List W / C or MVA Carrier: _____
Preferred way for us to contact you (Circle One): Phone / Postal Mail / Email

Acknowledgement of Receipt of Notice of Privacy Practices

A copy of the Notice of Privacy Practices will be provided to you upon request.

Consent For Treatment:

I hereby consent to evaluation, testing and treatment/surgery that are provided to me or the patient for whom I am responsible. This would include all doctors, nurses and interns that are affiliated with Carolina Surgery and Cancer Center.

Patient Signature: _____ Date: _____

If patient is a minor, please have the parent or legal guardian sign below:

Parent/Legal Guardian Signature: _____ Date: _____

Parent/Legal Guardian Name (Please Print): _____