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 #:_____ Today's Date:_____
Referring Dr & **Family Dr**:_____
Patient's Name:_____
Patient's SS #:_____ Patient's Birth Date:_____
Patient's Mailing Address:_____
City, State, Zip Code:_____
Patient's Cell #:_____ Patient's Home #:_____
Patient's Email Address:_____
Marital Status (Circle One): Single / Married / Divorced / Separated / Widowed
Emergency Contact:_____ Phone #:_____
Relationship To Patient:_____
Pharmacy:_____
Preferred Method Of Contact (Circle One): Phone / Postal Mail / Patient Portal

Primary Insurance Policy Holder: Self / Spouse / Parent
Responsible Party's Name:_____ DOB:_____
Phone#: _____ Soc Sec#:_____
Name Of Employer: _____
Worker's Compensation: ( ) Motor Vehicle Accident: ( ) Date Of Accident: _____

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

Parent/ Legal Guardian Signature: _____ Date: _____

Parent/ Legal Guardian Name (Please Print): _____