Lancaster Cancer Center
Care Beyond Treatment

Patient Registration

Name: _____
Date of Birth: _____
Birth Place:
City: _____
State: _____

Marital Status: ❑ S ❑ M ❑ W ❑ D (select one)
Social Security #:_____
Email Address: _____
Ethnicity: ❑ Hispanic or ❑ Latino Patient Declined
❑ Non Hispanic or Latino

Do you have a Living Will? ❑ Yes (please bring a copy) ❑ No
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____

Race: ❑ Caucasian ❑ Black or African American
❑ Native American ❑ Chinese ❑ Japanese ❑ Asian
❑ Multiracial ❑ Other ❑ Undetermined

Employed: ❑ Retired ❑ Disabled ❑ Unemployed ❑ Homemaker
Employer's Name: _____
Occupation: _____
Address: _____
Work Phone #: _____

Spouse Name: _____
Phone: _____
Spouse's Employer: _____
Primary Insurance: _____
Family Physician: _____
Referring Physician: _____

Date of Birth: _____
Social Security #: _____
Occupation: _____
Secondary Insurance: _____
Phone: _____
Phone: _____

In Case of Emergency:

Contact: _____ Relationship: _____ Phone: _____
Contact: _____ Relationship: _____ Phone: _____

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: _____