OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PATIENT REGISTRATION

PLEASE PRINT CLEARLY

Name: _____ Check One: ☐ Female ☐ Male Age: _____

Date of Birth (MONTH/DAY/YEAR): _____ Are you: ☐ Single ☐ Married ☐ Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Primary Phone: _____ Secondary Phone: _____

SSN: _____ Preferred Language: _____

Preferred contact method: ☐ Mail ☐ Phone ☐ Text Message Email: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ Other

Pharmacy: _____ Address: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Patient Employer: _____

Address: _____ Phone: _____

Occupation: _____

Spouse Name: _____ Date of Birth: _____ SSN: _____

Spouse Employer: _____

Spouse Employer Address: _____ Spouse Employer Phone: _____

Next of Kin: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
(not living with you)

INSURANCE AND PAYMENT

Primary Insurance: _____ Employer: _____

Policy Holder: _____ ID#: _____ Group#: _____

Secondary Insurance: _____ Employer: _____

Policy Holder: _____ ID#: _____ Group#: _____

Please enter the information below for the person responsible for the bill, if other than the patient.

Responsible Party Name: _____

Date of Birth: _____ Relationship: _____ SSN: _____

Address: _____

Home Phone: _____ Cell: _____

1.) Oklahoma Cancer Specialists and Research Institute may disclose your health information for public health activities such as cancer/tumor registry.

2.) I understand that I have a right to request and receive a Notice of Practices from Oklahoma Cancer Specialists and Research Institute.

This Agreement/Consent will remain in effect unless revoked by me in writing.

I have read the above statements and accept the terms. A copy of this agreement is on file with Oklahoma Cancer Specialists and Research Institute.

Standard messaging and data rates may apply.

Patient

Signature: _____ Date: _____

Spouse or Responsible Party

Signature: _____ Date: _____

MRN: _____ Provider: _____ Site: _____ Verified by: _____