Tallahassee Cancer Institute

Registration Form

1653 Mahan Center Blvd.
Tallahassee, FL 32308
Tel: 850-219-8000
Fax: 850-219-8003

Patient Name:_____ **SS#**_____ **Date of Birth:**_____

Address:_____ **Sex: M** ☐ **F** ☐

City:_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Pharmacy Preference (Name and address): _____

Referring Physician:_____ **Patient Race:**_____

Employer:_____ **Phone:** _____

Address:_____ **Suite#**_____

City:_____ **State:**_____ **Zip:**_____

Responsible Party/Guardian Name:_____ **Relationship:**_____

Address:_____ **Apt#**_____

City:_____ **State:**_____ **Zip:**_____

Phone: _____ **Date of Birth:**_____ **SS#**_____ **Sex: M** ☐ **F** ☐

Primary Insurance Carrier:_____

Policy Holders Name:_____ **Date of Birth:** _____

Employer:_____ **Employer's Phone:**_____

Group#_____ **Policy or ID#**_____

Insurance Company Address: _____

City:_____ **State:**_____ **Zip:**_____

Secondary Insurance Carrier:_____

Policy Holders Name:_____ **Date of Birth:**_____

Employer:_____ **Employer's Phone:**_____

Group#_____ **Policy or ID#**_____

Insurance Company Address: _____

City:_____ **State:**_____ **Zip:**_____

****Emergency Contact** Name:**_____ **Relationship:**_____

Address:_____ **Apt#**_____

City:_____ **State:**_____ **Zip:**_____ **Phone:**_____

You are to provide copies of your current Insurance Card(s) & Drivers License or Photo ID. We reserve the right to refuse treatment if these items are not provided. We also reserve the right to refuse treatment to those persons who use vulgarity or threats to staff or physicians.

AUTHORIZATION TO PAY BENEFITS TO FACILITY: I hereby authorize payment directly to _____. Not to exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed private insurance carrier payment, and if greater than such payment, I will be held responsible for that amount.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned provider to release any information required in the course of my examination or treatment to my insurance company or their contracted entities. (If patient is a minor, parent must sign)

Signature:_____ **Date:**_____

Revised Dec 12, 2018