



**FLORIDA
GYNECOLOGIC
ONCOLOGY**

(PLEASE PRINT)

PATIENT REGISTRATION

Name: _____ Date: _____

Date of Birth: _____ Social Sec. #: _____ Marital Status: S M W D

Permanent Address: _____

City: _____ State: _____ Zip Code: _____

Permanent Phone Number: () _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Local Phone Number: () _____

Name of Employer: _____

Work Phone: () _____

If student, name of school: _____

IF MARRIED OR A MINOR, PLEASE COMPLETE

Name of Spouse or Parent: _____

Social Security #: _____

Address (if different): _____

Employer: _____ Phone: _____

If Patient is a minor, list below those who may authorize treatment of child:

In Case of Emergency, Please Notify:

Name: _____ Phone: _____

Do you have health insurance? Yes No Type: HMO PPO Other: _____

If no, what will be your form of payment? _____

Insurance Company Name: _____ Is your spouse on this insurance plan? Yes No

Address: _____ City: _____ Zip Code: _____

Telephone: () _____ Name of Policy Holder: _____

Policy Number: _____ Group Number: _____/ID# _____

Referred By: _____ Telephone: () _____

Pharmacy Name: _____ Telephone: () _____

Authorized to Treat

The undersigned patient and/or responsible person or relative hereby consent(s) to authorize Florida Gynecologic Oncology, affiliated physicians and allied health personnel, to administer and perform any and all medical examination(s) and treatment(s) diagnosed and surgical procedures which may now, or during the course of the patient's care, be deemed advisable and/or necessary.

Authorization of Payment and Release of Records

I hereby authorize assignment of payments to Florida Gynecologic Oncology. I authorize the release of all records to process insurance claims, or to any physician I may be referred to.

Signature of Patient: _____ Date/Time: _____

Signature of Witness: _____ Date/Time: _____