

Appointment Date: _____

LCCC Initials: _____

PATIENT REGISTRATION

Updated _____

Updated _____

Updated _____

LCCC Office Location _____	Pre-Reg _____	Not Pre-Reg _____	Update _____	Date _____
LCCC Physician: _____		Diagnosis: _____		
Referring Physician: _____		_____		
First Name _____	Last Name _____			
Primary Care Physician: _____		_____		
First Name _____	Last Name _____			

PATIENT'S INFORMATION (PLEASE PRINT CLEARLY)

PATIENT'S NAME (LAST) (FIRST) (MI)		SOCIAL SECURITY NO.		DATE OF BIRTH		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PATIENT'S HOME ADDRESS				CITY		STATE	ZIP
HOME PHONE NUMBER	CELL PHONE NUMBER	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> Life Partner <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		RACE <input type="checkbox"/> HISPANIC / LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> AFR AMER / BLACK <input type="checkbox"/> OTHER _____		Preferred PHARM./ LAB. Pharm _____ Lab _____	
PATIENT'S EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> None <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY		PATIENT'S WORK NUMBER					
EMPLOYER'S NAME & ADDRESS				OCCUPATION			

INSURANCE INFORMATION

NAME OF FIRST INSURANCE / PHONE NUMBER		NAME OF SECOND INSURANCE / PHONE NUMBER	
NAME OF INSURED PERSON	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Life Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____	NAME OF INSURED PERSON	RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Life Partner <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____
INSURED PERSON'S SOCIAL SECURITY NUMBER / EMPLOYER NAME		INSURED PERSON'S SOCIAL SECURITY NUMBER / EMPLOYER NAME	
POLICY, CERTIFICATE OR ID NUMBER	GROUP NAME & NUMBER	POLICY, CERTIFICATE OR ID NUMBER	GROUP NAME & NUMBER
INSURANCE ADDRESS, CITY, STATE, ZIP	PHONE NUMBER	INSURANCE ADDRESS, CITY, STATE, ZIP	PHONE NUMBER

OTHER RESPONSIBLE PARTY'S OR SPOUSE'S OR SIGNIFICANT OTHER'S INFORMATION

NAME (LAST) (FIRST) (MI)		SOCIAL SECURITY NO.		DATE OF BIRTH		RELATION TO PATIENT	
HOME ADDRESS		CITY		STATE	ZIP	HOME PHONE NUMBER	
EMPLOYMENT STATUS <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____ <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY		PHONE NUMBER		OCCUPATION			
EMPLOYER'S NAME & ADDRESS				CITY		STATE	ZIP

EMERGENCY CONTACT PERSON'S INFORMATION

NAME (LAST) (FIRST) (MI)		ADDRESS		PHONE NUMBERS <input type="checkbox"/> HOME _____ <input type="checkbox"/> WORK _____	
RELATIONSHIP TO PATIENT					

SERVICES

Low Country Cancer Care P.C. SUPPORTS THE USE OF MID-LEVEL PROVIDERS. YOU MAY BE SEEN PERIODICALLY BY A NURSE PRACTITIONER AND/OR PHYSICIAN ASSISTANT.
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ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance or any other health plan to Low Country Cancer Care Associates, P.C. (LCCC) I request that payment of such benefits be made on my behalf directly to LCCC. I understand that I am financially responsible for all charges whether or not paid by said insurer(s). I agree to pay for all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible. I hereby authorize LCCC to release any information necessary to determine eligibility and/or reimbursement for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
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XX Patient Signature _____ Date: _____