

The Breast Center at Hope

(an affiliate of HOPE-A Women's Cancer Center)

PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____

Address _____

City _____ State _____ ZIP _____ Home # _____

Social Security # _____ NC Driver's License # _____

Employed By _____ Work # _____

Work Address _____

Husband's Name _____ Social Security # _____

Employed By _____ Date of Birth _____

Work Address _____ Work # _____

Alternate Contact _____ Relationship _____

Address _____ City _____ State _____ ZIP _____

Home # _____ Occupation _____

Employed By _____ Work # _____

Work Address _____

Person Responsible For Payment? _____

WE NEED A COPY OF YOUR INSURANCE CARD.

Please list insurance:

Primary _____ Policyholder _____

Secondary _____ Policyholder _____

Third _____ Policyholder _____

RELEASE AND ASSIGNMENT

I HEREBY AUTHORIZE The Breast Center at Hope/Hope-A Women's Cancer Center, P.A. to furnish information/**MEDICAL RECORDS** to insurance carriers and medical providers concerning my illness and treatments, and I hereby assign The Breast Center at Hope/Hope-A Women's Cancer Center, P.A. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature _____ **Date** _____