

Neuro-Oncology Associates PATIENT REGISTRATION FORM
3600 Gaston Avenue, Barnett Tower 605, Dallas, TX 75246

FOR OFFICE USE ONLY

Acct # _____

Today's Date: _____

Patient Information

Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Email Address	
Date of Birth		Age	Sex (circle one) Male Female	Social Security # Drivers License #
Referring Physician:		Physician Phone:	Physician City & State:	
Occupation	Employer	Employer Address		
Marital Status (circle one) Single Married Widowed Divorced Separated			Spouse's Name	
If Student, Indicate School		If Patient is a Minor, provide Name of Parent(s) or Legal Guardian (legal documentation required):		
Emergency Contact (not living at same address)			Emergency Contact Phone # ()	

Responsible Party

Guarantor Full Name: Last		First	Middle	(Maiden)
Address: (Street or Box)		City	State	Zip
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Drivers License #	
Date of Birth	Age	Sex (circle one) Male Female	Social Security #	Patient Relationship to Guarantor
Employer	Employer Address			

Insurance Information

Name of Primary Insurance Company 1.			Phone # ()	Name of Secondary Insurance Company 2.			Phone # ()
Mailing Address				Mailing Address			
City		State	Zip	City		State	Zip
Policy Number	Group Number	Effective Dates of Policy From: To:		Policy Number	Group Number	Effective Dates of Policy From: To:	
Policy Holder (if other than patient)		Date of Birth		Policy Holder (if other than patient)		Date of Birth	
Social Security #		Relationship to Patient		Social Security #		Relationship to Patient	
Policy Holder's Employer		Work Phone # ()		Policy Holder's Employer		Work Phone # ()	
Employer Address				Employer Address			
City		State	Zip	City		State	Zip

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Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice.

If patient is a minor:

I consent for _____ to authorize evaluation and treatment for my child named
(Name(s): First & Last)

herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

Signature of Patient, Parent, or Legal Guardian

Date

Financial Responsibility

I hereby authorize payment of medical benefits directly to HealthTexas Provider Network (hereinafter "HTPN") and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to HTPN. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of HTPN, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

Signature of Patient, Parent, or Legal Guardian

Date