



**Form must be completed in ink**

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status: S M D W

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different)  
\_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Sex: F M Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Exp. \_\_\_\_\_

Employer: \_\_\_\_\_ Work Address \_\_\_\_\_

Are you enrolled in a Hospice Program? Y N Name of Program: \_\_\_\_\_

Are you a resident of a Skilled Nursing or Convalescent Facility? Y N

Name of facility: \_\_\_\_\_

Do you have a Designated Conservator or Power of Attorney (POA)? Y N

Name: \_\_\_\_\_ Phone#:( ) \_\_\_\_\_

**SPOUSE INFORMATION**

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employed By: \_\_\_\_\_ Work or Day Phone ( ) \_\_\_\_\_

Work Address \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**WHO TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN ABOVE PERSONS)**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**PHYSICIAN INFORMATION**

Referring Physician \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_

Primary Physician \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_

Other Physician \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_

**INSURANCE INFORMATION**

Private or No Insurance – How do you intend to pay? CASH \_\_\_\_ CHECK \_\_\_\_ CREDIT CARD \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Member ID # / Policy # \_\_\_\_\_

Employer / Group # \_\_\_\_\_ Employer / Group # \_\_\_\_\_

**PLEASE SIGN & RETURN TO RECEPTIONIST**

I, the undersigned, assign directly to River West Radiation Therapy Center, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and hereby authorize River West Radiation Therapy Center to release and/or obtain medical records as needed for my treatment or to assist in obtaining insurance reimbursement on my behalf.

Date \_\_\_\_\_ Signature \_\_\_\_\_