Patient Name: ____
Last First Middle Initial

Address: ____
Street Apartment Number

City: ______________________ State: __________ Zip Code: ____________________

Home Phone: ______________________ Cell Phone: __________________________
Area code and Telephone # Area code and Telephone #

Email Address: ______________________________ May we contact you via email? ______

Employer: _________________________________ Work Phone Number: ____________

Marital Status: ________ Spouse's name and number____________________________

Alternate Contact Person (relationship to patient) and phone #: ____________________

Patient's Date of Birth: _____/_____/________ Social Security Number: _______-______-____________

Gender Identity: ☐ M ☐ F ☐ Other: please specify ____________________ ☐ Decline to answer

Language(s): ______________________ Ethnicity: Hispanic/Latino ☐ or Non-Hispanic/Latino ☐

Race (Please check one): ☐ African American ☐ Asian ☐ Caucasian ☐ Native American

☐ Pacific Islander ☐ Hispanic ☐ Other: ____________

Preferred method of contact (home phone, cell, or email):______________________________

Are you under the care of hospice? ☐ Y ☐ N Are you in a skilled nursing facility? ☐ Y ☐ N

Family Physician: __________________________ Referring Physician: ________________

Pharmacy of Choice: ____
Name Address or Intersection City/State/Zip

Insurance Information: Please fill out the following information regarding your insurance.

Primary Insurance	**Secondary Insurance**
Plan Name:	Plan Name:
Subscriber Name:	Subscriber Name:
ID Number: Group Number:	Subscriber DOB:
Co-Pay Amount:	ID Number: Group Number:

PLEASE TURN OVER

RE: Billing - Please read before signing:

Tacoma Valley Radiation Oncology Center will make every effort to obtain authorization for and bill your Medicare and/or private insurance company for the requested services.

Please read and initial each statement:

_______ I authorize the payment of insurance benefits to Tacoma Valley Radiation Oncology Center for the services provided to me.

_______ I authorize the release of medical information to my insurance company and to any other physicians participating in my medical care and for purposes of planning and delivery of treatment and internal health care operations.

_______ I acknowledge that I am responsible for the amounts not paid by Medicare and/or my private insurance company (I.e. deductibles, co-insurance, and co-payments).

_______ I agree to meet with the Tacoma Valley Radiation Oncology Center Financial Counselor to arrange a payment plan for any outstanding balances to make these payments as manageable as possible for myself and my family.

Signature: (Relationship to Patient) Date:

-------------------This portion of the form is to be completed by the TVROC staff. Thank you!-------------------

Insurance / Verification Data –

Identification verified by: ____
Staff Member Date

Identification Document Type: Driver's License Number____________________ Issue Date_________

Passport Number ________________________ Issue Date_________

Diagnosis Code: _____________ Description: ________________________________

Assigned Physician: ____

A photo copy of this form shall be deemed as valid and as effective as the original