



PATIENT REGISTRATION PROFILE  
Patient ID # (Office Staff Only): \_\_\_\_\_

Patient Name: \_\_\_\_\_  
First Middle Last

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

Home Phone: \_\_\_\_\_ Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security : \_\_\_\_\_

Marital Status (Check the One that applies) :  Single  Married  Divorced

Are you employed?  No  Yes Employer Name: \_\_\_\_\_

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

Date of Retirement or Disability (only if applicable): \_\_\_\_\_

Primary Care Giver: \_\_\_\_\_  
Name Relationship Phone

Emergency Contact: \_\_\_\_\_  
Name Relationship Phone

Primary MD: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Insurance: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy Holder's Social Security Number: \_\_\_\_\_

OVER PLEASE

Guarantor (person responsible for payment 18 years or older- if different from patient)

Name:

First

Middle

Last

Address

Street

City

State

Zip

Phone:

Other:

Birthdate:

Social Security :

Relationship to patient:

Do you have a religious preference?

Yes

No

(please tell us which)

I request and give permission for my physician, associated with Cancer Care associates of Fresno Medical Group, Inc. (CCA) to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me. I authorize CCA to release information from my medical record to my insurance carrier(s), or government agencies for the processing of claims for medical benefits. I request that my insurance carrier(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to CCA on my behalf.

I understand that all accounts are the full responsibility of myself, the patient and/or the patient's responsible party/guarantor. CCA will assist patients in obtaining insurance benefits when those benefits are assigned to CCA. It is the patient's responsibility to make sure insurance payments are processed and paid promptly.

Patient or Legal guardian's Signature:

Date:

Initials: