REGISTRATION FORM

Pittsburgh Gynecologic Oncology

PATIENT INFORMATION

Date:

Name:	**Date of Birth:**	**Social Security Number:**
Address:	**Telephone:** **Home:** **Work:**	
Emergency Contact #1:	**Relationship #1:**	**Emergency Contact Phone:**
Emergency Contact #2:	**Relationship #2:**	**Emergency Contact Phone:**
Cardholder Name (if different from patient) **Cardholder Social Security:** **Cardholder Date of Birth**		**Cardholder Phone:**

PRIMARY INSURANCE (Please present insurance card for us to photocopy.)

SECONDARY INSURANCE (Please present card for us to photocopy.)

Please Read and Sign Below:

Direct Payment Request and Authorization to Release Medical Information

"I hereby authorize the release of information acquired during the course of my examination and authorize to the Center for Medicare and Medicaid Services and its agents or any other third party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to include Medicare benefits directly to my physician. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until canceled in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof."

Patient/responsible party ______________________________ Date ______________

FILE under Insurance (inside back cover of chart)