



\*\* To be completed using black ink\*\*

Breastlink Patient Registration

Patient Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Home Ph: ( ) \_\_\_\_\_ Cell Ph: ( ) \_\_\_\_\_ Wk Ph: ( ) \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Email address: \_\_\_\_\_

Gender: \_\_\_ Female \_\_\_ Male Marital Status (circle one): Single Married Divorced Widowed

Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_ If student, Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

Employer/School Address: \_\_\_\_\_

Name of Referring Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address of Referring Provider: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PCP Name (if different from above): \_\_\_\_\_ Office Ph: ( ) \_\_\_\_\_

PCP Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

How did you hear about us? [ ] Website [ ] Friend [ ] Family member [ ] Referring MD: Name: \_\_\_\_\_ [ ] Other \_\_\_\_\_

Insurance Guarantor Information:

Name of Insurance Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Primary Insurance Information:

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Specialist Co-pay amount (if applicable): \$ \_\_\_\_\_

Insurance billing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Secondary Insurance Information:

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Specialist Co-pay amount (if applicable): \$ \_\_\_\_\_

Insurance billing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Authorization for Assignment of Benefits: By my signature below, I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company). Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, that I am fully responsible for all charges/services provided at my appointment and payment is due at the time of service.

Authorization and Consent for Medical Care/Treatment: By my signature below, I hereby authorize Breastlink to furnish the necessary medical treatment or procedures including but not limited to laboratory procedures, chemotherapy agent or such drugs, surgical procedures, and supplies as ordered by the attending physicians, his assistants, or designees. I further recognize that the physicians who practice at Breastlink may not be employees or agents of Breastlink but independent physicians. Breastlink contracts with these physicians for services normally provided and questions relating to care that my physician has given or ordered should be addressed to him/her.

Lifetime Medicare B Signature Authorization: By my signature below, I authorize my holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of Breastlink and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for the deductible and co-insurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_