The Breast Center at Hope

(an affiliate of HOPE-A Women's Cancer Center)
PATIENT REGISTRATION

Patient's Name _____ Date of Birth _____

Address _____

City_____State_____ZIP_____ Home # _____

Social Security # _____ NC Driver's License # _____

Employed By _____Work # _____

Work Address_____

Husband's Name _____Social Security # _____

Employed By _____Date of Birth_____

Work Address _____ Work # _____

Alternate Contact _____ Relationship _____

Address _____City_____State_____ZIP_____

Home # _____ Occupation _____

Employed By _____Work # _____

Work Address _____

Person Responsible For Payment? _____

WE NEED A COPY OF YOUR INSURANCE CARD.
Please list insurance:

Primary _____Policyholder _____

Secondary _____Policyholder _____

Third _____Policyholder _____

RELEASE AND ASSIGNMENT

I HEREBY AUTHORIZE The Breast Center at Hope/Hope-A Women's Cancer Center, P.A. to furnish information/**MEDICAL RECORDS** to insurance carriers and medical providers concerning my illness and treatments, and I hereby assign The Breast Center at Hope/Hope-A Women's Cancer Center, P.A. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature _____ **Date** _____