**Attention**: Do **NOT** fill out this "Austin Center for Radiation Oncology Patient Registration Form" if your Urologist is listed below. You are already registered through their office.


Brett Baker, M.D.


Carl J. Bischoff, M.D.


R. Grady Bruce, M.D.


David Cuellar, M.D.


Naresh "Vic" Desireddi, M.D.


Michael Floyd, M.D.


David Freidberg, M.D.


David Greenwell, M.D.


John J. Horan, M.D.


Jeffrey N. Kocurek, M.D.


Shaun Maloney, M.D.


Michael L. McClelland, Jr., M.D.


Robert Northway, M.D.


David Phillips, M.D.


Steve Pickett, M.D., Ph.D.


Peter Ruff, M.D.


Herb Singh, M.D.


John Williamson, M.D.

THE AUSTIN CENTER
FOR
RADIATION ONCOLOGY

**1020 West 34th Street**

# PATIENT REGISTRATION FORM

**TODAY'S DATE**: _____/_____/_____

REFERRING UROLOGIST_____ PRIMARY CARE DR_____

PATIENT NAME_____
LAST FIRST M.I.

HOME ADDRESS_____

_____
CITY STATE ZIP

HOME #_____ CELL #_____ WORK #_____

EMAIL ADDRESS _____

DATE OF BIRTH_____/_____/_____ AGE_____ S.S.#_____-_____-_____

DRIVER'S LICENSE #_____/STATE_____ SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ SELF-EMPLOYED ☐ RETIRED ☐ OTHER

EMPLOYER_____ OCCUPATION_____

## EMERGENCY CONTACT INFORMATION

NAME_____ RELATIONSHIP TO PATIENT_____

PHONE #_____ ALTERNATE #_____

# INSURANCE INFORMATION

DO YOU HAVE PRIVATE INSURANCE? ☐ YES ☐ NO

DO YOU HAVE MEDICARE? ☐ YES ☐ NO

DO YOU HAVE A MEDICARE SUPPLEMENT OR SECONDARY INSURANCE? ☐ YES ☐ NO

**MEDICARE INSURANCE INFORMATION (IF APPLICABLE)**

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

INSURED DATE OF BIRTH (DOB):_____/_____/_____ INSURED S.S.#_____-_____-_____

MEDICARE ID#:_____ EFFECTIVE DATE:_____/_____/_____

**PRIMARY INSURANCE INFORMATION –IF YOU HAVE A MEDICARE REPLACEMENT POLICY PLEASE FILL OUT THIS SECTION**

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

INSURED DATE OF BIRTH (DOB):_____/_____/_____ INSURED S.S.#_____-_____-_____

INSURED EMPLOYEE NAME (IF APPLICABLE)_____ PHONE_____

INSURED COMPANY NAME_____ EFFECTIVE DATE_____

POLICY/ID #:_____ GROUP #:_____ COPAY:_____

**SECONDARY/MEDICARE SUPPLEMENT INSURANCE INFORMATION (IF APPLICABLE)**

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

INSURED DATE OF BIRTH (DOB):_____/_____/_____ INSURED S.S.#_____-_____-_____

INSURED EMPLOYEE NAME (IF APPLICABLE)_____ PHONE_____

INSURED COMPANY NAME_____ EFFECTIVE DATE_____

POLICY/ID #:_____ GROUP #:_____ COPAY:_____

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVES RENDERED AT THE AUSTIN CENTER FOR RADIATION ONCOLOGY. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO BE PAID TO THE PHYSICIAN. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I HAVE READ AND CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE STAFF OF ANY CHANGES IN MY HEALTH STATUS OR ANY CHANGES IN THE ABOVE INFORMATION.

_____ _____/_____/_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE SIGNED