Virginia Cancer Care

19415 Deerfield Avenue
Suite 107
Leesburg, VA 20176
Phone 703-729-6030
Fax 703-729-1446

1860 Town Center Drive
Suite 260
Reston, VA 20190
Phone 703-794-4400
Fax 703-729-1446

Patient Registration Form

Patient Name: _____ **Date of Birth**: _____ Age: _____

Sex: O **Male** O **Female**

Language Preferred: _____ **Ethnicity:** _____

Address: _____

City, State, Zip: _____

Home Phone #: _____ **Work** #: _____ **Cell** #: _____

Social Security #: _____ **Email**: _____

Emergency Contact: _____ **Emergency Phone**: _____

Parent/Guardian (if patient is a minor):
Name: _____ Relationship: _____
Address (if different from above: _____
Contact Phone: _____ Email: _____

Medical Insurance Information

Primary Insurance: _____ **Policy #:** _____ **Group #:** _____
Policy Holder: _____ **Relationship:** _____ **SS#:** _____

Secondary Insurance: _____ **Policy #:** _____ **Group #:** _____

Medicare #: _____ **Medicaid** #: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer).

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any 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 insurance benefits either to myself or to the party who accepts assignment. I have received notice of this organization's privacy policies.

Signature: _____ Date: _____

Updated: 6/12/2017