Please complete all pages of this registration form prior to your appointment. You can either fax it in advance of your appointment to:

253-382-6301

or bring it with you to your first appointment.

Patient Registration Form - 1 of 2

Referral Information: *(Please Print)*

Patient Referred By	Relationship	Today's Date

Patient Information:

Patient Name		Date of Birth
Street Address	City, State	Zip
Phone Number	Cell Number	Social Security Number
Email Address		
Marital / Civil Union Status	Age	Sex
Employer		Work Number
EmployerAddress	City, State	Zip

Emergency Contact Information:

Name		Phone Number
Relationship		Phone Number
Street Address	City, State	Zip

Physician Information:

Primary Care Provider		Phone Number
Street Address	City, State	Zip
Other Physicians		Phone Number
Street Address	City, State	Zip
Other Physicians		Phone Number
Street Address	City, State	Zip

Patient Registration Form - 2 of 2

Patient Name | Today's Date

Primary Insurance Information: *(Please Print)*

Insurance Name (or see card)

Identification Number | Group Number

Subscriber's Name | Date of Birth

Subscriber's Address | City, State | Zip

Subscriber's Relationship to Patient | Subscriber's SSN#

Cardholder's Employer | Phone Number

Other Insurance Information: *(If Applicable)*

Insurance Name (or see card)

Identification Number | Group Number

Subscriber's Name | Date of Birth

Subscriber's Address | City, State | Zip

Subscriber's Relationship to Patient | Subscriber's SSN#

The physicians of Salish Cancer Center participate in the Medicare Program and several PPO/HMO networks. We do file claims for our patients as a courtesy. If insurance companies do not respond within 60 days, we look to the guarantor for payment.

Other Insurance Information:

I authorize payment directly to Salish Cancer Center for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for non-covered services, co-pays, and deductibles per my insurance policy(ies). I also understand I am ultimately financially responsible for this account whether or not paid by my insurance.

I further authorize my provider of the office stated above to release any information required to secure the payment of said benefits. I authorize the use of this signature as a release for all insurance submissions and requests for any information from other physicians, providers or suppliers of service deemed necessary for my care and payment.

Patient's Signature | Date

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