First Dayton CyberKnife **Registration Form** **First Dayton Cancer Care**

Last Name	First Name	MI	Date of Birth

Street Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Social Security #

Marital Status	Are You Currently Staying in a Nursing Home or Assisted Living Center
☐Single ☐ Married ☐ Widowed ☐ Divorced	☐ Yes ☐ No * If yes please list the name, address & phone # _____ _____
Emergency Contact	Contact Phone#

Email Address			
Primary Insurance	Copay $	Secondary Insurance	Copay $

Primary Care Physician Info. Name, Address & Phone #	Specialist Physician Info. Name, Address & Phone # (surgeon, urologist, neurologist pulmonologist, etc.)	Specialist Physician Info. Name, Address & Phone # (surgeon, urologist, neurologist, pulmonologist etc.)
_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

Ethnicity	Race
☐ Hispanic or Latino ☐ NOT Hispanic or Latino	☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Asian

How did you hear about our practice?
☐ Family ☐ Friend ☐ Newspaper ☐ Radio ☐ TV ☐ Phone Book ☐ Internet ☐ Signage
☐ Insurance Directory ☐ Other Physician ☐ Hospital

I hereby authorize my insurance benefits to be paid directly to First Dayton Radiation Oncology. I also recognize that I am responsible to pay for non-covered services or in the event I do not have insurance coverage I am responsible for all charges for services rendered while I am uninsured. I hereby authorize the release of pertinent medical information to the above named insurance carrier(s).

Signature: _____ Date: _____

CONFIRMED INFORMATION

_____
Initials & Date

_____
Initials & Date

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Initials & Date

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Initials & Date

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Initials & Date

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Initials & Date