ANCHORAGE & VALLEY
RADIATION THERAPY CENTERS

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PATIENT INFORMATION

Patient Name ______________________ DOB ______ / ______ / ______ SSN ______ - ______ - ______

Mailing Address ______________________

City ______________________ State ____________ Zip Code ____________

Primary Phone ____________ ❑ Cell ❑ Home Alternate Phone ____________ ❑ Cell ❑ Home

Email** ______________________

Employer ______________________ Occupation ______________________

Please tell us how you heard about us (Radio/TV/Friend/Family, etc.) ______________________

Sex ❑ Male ❑ Female Military ❑ Are you a veteran? ❑ Are you active or retired military?

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced Spouse's Name ____________ May we contact? ❑ Yes ❑ No

Ethnicity ❑ White or Caucasian ❑ Black or African American ❑ Asian ❑ Native American or Alaska Native
❑ Native Hawaiian or Other Pacific Islander ❑ Other ❑ Unknown ❑ I decline to answer

Parent/Legal Guardian (if not patient) ______________________

Emergency Contact
Name ______________________ Phone ____________ Relationship ____________

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance ______________________ Policy Holder ______________________

Ins. Phone ______________________ Policy Holder's SSN ______ - ______ - ______

Policy # ______________________ Policy Holder's DOB ______ / ______ / ______

Group # ______________________ Policy Holder's Employer ______________________

SECONDARY INSURANCE

Insurance ______________________ Policy Holder ______________________

Ins. Phone ______________________ Policy Holder's SSN ______ - ______ - ______

Policy # ______________________ Policy Holder's DOB ______ / ______ / ______

Group # ______________________ Policy Holder's Employer ______________________

PATIENT PAYMENT AGREEMENT

I understand that I am responsible for my medical bill and accept responsibility for any charges not covered and paid by my insurance company or other third party resources.

- By signing below, I authorize the release of my medical records to the insurance carrier as may be necessary to determine benefits and to process claims for health care services provided to the above named patient.
- I authorize assignment of Medicare/Medicaid, other federal/state agents or any commercial insurance carriers to pay benefits directly to the provider of service(s).
- This is a Lifetime insurance authorization granting the provider authority to file claims on my behalf.

In addition to the above patient payment agreement, I sign below acknowledging receipt of the office's NOTICE OF PRIVACY PRACTICES

Signature ______________________ Date ____________

Witness ______________________ Date ____________

** Your email address will only be used to provide you information about events and classes we are hosting/sponsoring. We will not share this information.