

# Associates in Radiation Oncology, P.C.

## REGISTRATION FORM

**Anu Gupta, M.D.**  
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Date \_\_\_\_\_ Dr. \_\_\_\_\_ Ref Dr. \_\_\_\_\_ Chart # \_\_\_\_\_

### PATIENT INFORMATION

Patient's Last Name		First	Middle Initial	Email Address	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					
Birth Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security		Home Phone No.	Cell Phone No.
Address		City	State	ZIP Code	
Occupation		Employer		Employer Phone No.	
Employer Address		City	State	ZIP Code	

### INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

<b>Primary Insurance</b>		Policy Number	Plan/Group Number
Subscriber's Name		Subscriber's Social Security	Subscriber's Birth Date
Subscriber Phone No.	Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
<b>Secondary Insurance</b>		Policy Number	Plan/Group Number
Subscriber's Name		Subscriber's Social Security	Subscriber's Birth Date
Subscriber Phone No.	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		

### IN CASE OF EMERGENCY

Name	Relationship to Patient	Home Phone No.	Work Phone No.
Emergency Contact Address		City	State ZIP Code

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ASSOCIATES IN RADIATION ONCOLOGY, P.C. or insurance company to release any information required to process my claims. My permission is given to use a copy of this authorization in place of the original. This authorization may be revoked by either myself or ASSOCIATES IN RADIATION ONCOLOGY, P.C. at any time, provided it is done in writing. I understand this is a LIFETIME AUTHORIZATION and can only be revoked by myself or ASSOCIATES IN RADIATION ONCOLOGY, P.C. in writing. I understand and agree that should my account be turned over to a collection agency and/or attorney, all fees incurred will become my responsibility and be added to my principal balance.

X Patient/Guardian Signature	Date
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