MICHIGAN STATE UNIVERSITY
HEALTHTEAM

PLEASE PRINT – COMPLETE BOTH PAGES

MRN ____
(for office use only)

Breslin Cancer Center
MSU Hematology/Oncology

PATIENT REGISTRATION

Date ______________________________

PATIENT INFORMATION

Patient Name:____ SS#:_________________________
Last First M.I.

Age: __________ Date of Birth: _______________ Male Female Marital Status: ___________ Email: _____________________

Address: ____
Street/Apt. # City State ZIP

Phone: Home ____________________________ Work: _________________________ Cell: ____________________________

Occupation: ____ Employer: ____

Employer's Address: ____
Street City State ZIP

MSU Student: Yes No If Yes, Student #: ____ MSU Athlete? Yes No

Emergency Contact Person #1: ____ Relationship:
____

Phone: Home ______________________________ Work: __________________________ Cell: __________________________

Emergency Contact Person 2: ____ Relationship: __________________

Phone: Home ______________________________ Work: __________________________ Cell: __________________________

Primary Care Physician: ____ Phone ____________________________

Address: ____
Street City State ZIP

Referring Provider (if not PCP): ____ Phone: ___________________________

Address: ____
Street City State ZIP

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Person Responsible for Payment:____ SS#:_____________________
Last First M.I.

Date of Birth: ____________________________ SS#: _________________________ Relationship to Patient: __________________

Address: Same as Patient ☐ ____
Street/Apt. # City State ZIP

Phone: Home ____________________________ Work: _________________________ Cell: ____________________________

Employer's Address: ____
Street City State ZIP

Other Parent's Name: ____ Date of Birth: ____________________

Address: Same as Patient ☐ ____
Street/Apt. # City State ZIP

Phone: Home ____________________________ Work: _________________________ Cell: ____________________________

INSURANCE INFORMATION

INSURANCE PLAN: ____ Effective Date: ______________________ Primary:_____ Secondary _____

Insurance Plan Address: ____

Insurance Plan Phone #: _____________________ Auth/Precert Phone #: ____________________ Customer Service Phone #:__________________

Name of policy holder: ____ Date of Birth: ___________________ Gender: Male Female

Employer and Address: ____

SSN#: __________________________________ Relationship to Patient: __________________________________

Policy holder address/Phone #: ____

Contract/ID/Group #: ____ Service Plan #: ____________________ Coverage Type ________________

Primary Care Co-pay: ______________ Specialty Co-pay:______________ Mental Health Co-pay: ______________ PT/SP/OT Co-Pay: _____________

INSURANCE PLAN: ____ Effective Date: ______________________ Primary:_____ Secondary _____

Insurance Plan Address: ____

Insurance Plan Phone #: _____________________ Auth/Precert Phone #: ____________________ Customer Service Phone #:__________________

Name of policy holder: ____ Date of Birth: ___________________ Gender: Male Female

Employer and Address: ____

SSN#: __________________________________ Relationship to Patient: __________________________________

Policy holder address/Phone #: ____

Contract/ID/Group #: ____ Service Plan #: ____________________ Coverage Type ________________

Primary Care Co-pay: ______________ Specialty Co-pay:______________ Mental Health Co-pay: ______________ PT/SP/OT Co-Pay: _____________

INSURANCE PLAN: ____ Effective Date: ______________________ Primary:_____ Secondary _____

Insurance Plan Address: ____

Insurance Plan Phone #: ______________________ Auth/Precert Phone # ___________________ Customer Service Phone #:__________________

Name of policy holder: ____ Date of Birth: ___________________ Gender: Male Female

Employer and Address: ____

SS#: __________________________________ Relationship to Patient: __________________________________

Policy holder address/Phone #: ____

Contract/ID/Group #: ____ Service Plan #: ____________________ Coverage Type ________________

Primary Care Co-pay: _______________ Specialty Co-pay:_____________ Mental Health Co-pay: ______________ PT/SP/OT Co-Pay: _____________

WORKERS COMPENSATION/AUTO LIABILITY: ________________ Primary _________________ Secondary Authorization Required? Yes No

Carrier: ____ Case/Claim#: ______________________________

Claims Address: ____

Phone #: ____ Contact Person: ____

Date of Injury/Accident: ____