Peninsula cancer center

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REGISTRATION FORM

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Employer/Occupation: _____ If retired, date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email*: _____ May we contact you by email? ☐ Yes* ☐ No

*You must provide an email address to have access to view, download or transmit your personal health information via our patient portal. If you elect to opt out by not providing an email, you may sign up in future at our clinic by completing a portal sign-up request form and providing a valid email address at that time.

Contact Preference: ☐Home Phone ☐Cell Phone ☐Work Phone ☐Email* ☐Other _____

May we leave a detailed message? ☐Yes ☐No How did you hear about us? _____

Language: _____ Ethnicity: _____ Race: _____

Gender: ☐Male ☐Female Children: _____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Domestic Partner

Partner's or Emergency Contact's Information: May we contact in an emergency? ☐ Yes ☐ No

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I authorize Peninsula Cancer Center to discuss my protected health information with the following family/friends:

Name:_____ Relationship/ Phone: _____

Name:_____ Relationship/ Phone: _____

Electronic Prescription Consent Primary Pharmacy & Location: _____

_____

I authorize Peninsula Cancer Center to download my electronic prescription history.

Signature: _____ Date: _____

Rev. 6-6-17

Please fill out the form and bring it with you to your appointment. Note that any item left blank will indicate you prefer to not give that information. Please bring photo identification and insurance card(s). Thank you.

(Due to privacy concerns, the completed form cannot be e-mailed)