

# The Blood and Cancer Clinic P.A.

1565 Purdue Drive, Suite 301  
FAYETTEVILLE, NC 28303  
Telephone # (910) 483-8586  
Fax # (910) 483-9212

This is on a \_\_\_\_\_ (day of the week) at \_\_\_\_\_ AM/PM.

*Shirish D. Devasthali, M.D.*  
*Tariq Nazir, M.D.*  
*Diplomates of American Board of*  
*Medical Oncology, Hematology and Internal Medicine*

## NEW PATIENT PRE-REGISTRATION FORM

Date: \_\_\_\_\_

Please complete all required information below and return it to the front desk as soon as possible. Thank you for your cooperation.

Patient Name: \_\_\_\_\_  
Last First Middle

Patient Address: \_\_\_\_\_  
Street City State Zip Code

Patient Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Patient Telephone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Patient Place of Employment: \_\_\_\_\_

Employment Address: \_\_\_\_\_  
Street City State Zip Code

Employers' Telephone: \_\_\_\_\_ How long employed there? \_\_\_\_\_

Spouse's Name/Employment: \_\_\_\_\_

Spouse's DOB: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_



# The Blood and Cancer Clinic P.A.

1565 Purdue Drive, Suite 301  
FAYETTEVILLE, NC 28303  
Telephone # (910) 483-8586  
Fax # (910) 483-9212

**IF THE PATIENT IS NOT THE SAME PERSON AS THE RESPONSIBLE PARTY, PLEASE FULLY COMPLETE THIS SECTION AS WELL.**

**Responsible Party Name:** \_\_\_\_\_  
Last First Middle

**Responsible Party Address:** \_\_\_\_\_  
Street City State Zip Code

**Responsible Party Telephone:** Home \_\_\_\_\_ Work: \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Place of Employment:** \_\_\_\_\_

**Employment Address:** \_\_\_\_\_  
Street City State/Zip code

**Employers' Telephone:** \_\_\_\_\_ **How long employed there?** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Nearest Relative NOT living in**

**household:** \_\_\_\_\_  
Last First Middle

**Address of Relative:** \_\_\_\_\_  
Street City State Zip code

**Relative Telephone:** Home \_\_\_\_\_ Work: \_\_\_\_\_  
.....

**In case of emergency, I authorize for Mr./Ms.** \_\_\_\_\_

**To be contacted at the following telephone numbers** \_\_\_\_\_.

**I hereby authorize The Blood and Cancer Clinic, P.A. to obtain my medical records from any physician or medical facility where I have received treatment. I also authorize the release of medical information to my insurance company and file on behalf of me to the insurance company.**

**SIGNATURE OF PATIENT** \_\_\_\_\_ **Date:** \_\_\_\_\_