ONCOLOGY REFERRAL NETWORK OF AMERICA

# Patient Registration Form

Please try to complete as much information as possible, so that we may arrange an appointment for you. Print this form and once complete, send via fax to **305-397-1148** or email to ***info@ornoa.com***

Last name: _____ First name: _____ Middle initial: _____

Age: _____ Gender: **M** ○ **F** ○ Date of birth: _____

Home address in your country: _____

City/State/Zip Code: _____ Country: _____ Primary language: _____

Country passport issued at : _____ Passport Number: _____

Telephone w/ country & city code: _____ Cell number: _____

Email: _____ Fax number: _____

Employer: _____ Occupation: _____ Employer Tel: _____

Contact in case of an emergency: _____ Relationship: _____ Tel: _____

## REFERRING DOCTOR'S INFORMATION

Referring doctor's name: _____ Specialty: _____

Referring doctor's telephone: (country and city code) _____

## INSURANCE INFORMATION

Do you have insurance that will cover your medical services in the United States? **Yes** ○ **No** ○

Insurance company name: _____

Policy holder's name: _____ Policy number: _____

Group: _____ Insurance Telephone number: _____

Insurance address: _____

**Patient's relationship to policy holder:**

**Self** ○ **Spouse** ○ **Child** ○ Other: _____

Name of person responsible for payment: _____

Relationship: _____ Telephone: (country and city code) _____

Address: _____ City/State/Zip Code: _____

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## APPOINTMENT REQUEST

Primary diagnosis or clinical problem which brings you to seek a physician ?

_____

_____

_____

_____

Are you ambulatory? **Yes** ○ **No** ○

Please list any physical disabilities: _____

What date would you be able to come to South Florida : _____

Would you like us to assist you with lodging or ground transportation? **Yes** ○ **No** ○

If known, what physician or specialist would you like to see? _____

Have you ever had cancer? **Yes** ○ **No** ○ If so, what type: _____

Have you had recent surgery? **Yes** ○ **No** ○ If so, what type: _____

How did you hear about Oncology Referral Network of America?

**Referred by Physician** ○ Name of doctor: _____

**From the Web** ○ **From the radio or newspaper** ○

**Friend or family member** ○ Name: _____

Other: _____

This is not a legal agreement or contract. This registration form simply collects general information about a person wishing to receive non emergency care from a physician or center in South Florida. We will use this information to best match the patient's needs with the appropriate specialists. Thank you!

**Oncology Referral Network of America, LLC**
Tel: 305-763-7997
Fax: 305 -397-1148
Email: ***info@ornoa.com***