Broward Oncology Associates, P.A.
NEW PATIENT PRE-REGISTRATION SHEET

LAST NAME: ____

FIRST NAME: ____

(Be sure the spelling is correct and verified as this is how the patient will be entered into the computer)

DOB (M/D/YYYY) ____________________ SSN ________________________

ADDRESS ____

____

____

____

PHONE #: (Home) _________________________________

(Cell) _________________________________

(Be sure this is a number where patient can be contacted to confirm appt. and/or change appt. if we need to cancel)

DIAGNOSIS:

____

(Be sure the patient is making an appt. with the right doctor for the right reason/diagnosis)

REFERRING MD:

____

(Include the phone # if the patient makes the appt., if necessary to contact the doctor) We need to have a referring MD or attending, not just friend, family, etc.

PRIMARY CARE PHYSICIAN ____

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RECORDS: ____

(Indicate whether records will be faxed or the patient will bring, we need to be sure to have all the records prior to the appt., i.e. pathology, bloodwork, Xrays)

INSURANCE:
____

(Be sure to check if a referral/authorization is required and make sure the patient is aware that we MUST have the referral/authorization prior to the appt.)

Physician Preference (check one):
___Luis Barreras, M.D - _____Francisco Belette, M.D. - ____ No Preference

Is this your first office visit? ________________

WHO MADE THE APPT:
____

(Indicate whether made by the patient or the referring doctor; if made by the doctor's office, we need the phone # of doctor, including PCP and/or surgeon depending on the office that made the appt.).