PATIENT REGISTRATION

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST _____

SEX _____ DATE OF BIRTH _____/_____/_____

MARITAL STATUS □ MARRIED □ WIDOWED □ PARTNER
□ DIVORCED □ SINGLE □ OTHER

EMPLOYMENT
□ EMPLOYED □ RETIRED □ STUDENT
□ OTHER_____

EMPLOYER'S NAME_____

ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

EMPLOYER'S PHONE (_____) _____

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____

PHYSICAL ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE (_____) _____

CELL PHONE (_____) _____

EMAIL_____

SEASONAL ADDRESS_____

CITY_____STATE_____ZIP_____

SEASONAL PHONE (_____) _____

REFERRING PHYSICIAN_____

PRIMARY PHYSICIAN_____

PREFERRED PHARMACY AND PHONE_____

_____

DEMOGRAPHIC & PREFERRED LANGUAGE (REQUIRED BY FEDERAL MANDATE)

RACE □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Other or Prefer not to answer

ETHNICITY □ Hispanic or Latino □ Not Hispanic or Latino □ Other or Prefer not to answer

PREFERRED LANGUAGE □ English □ Portugese □ Spanish □ French □ Other or Prefer not to answer

EMERGENCY CONTACT

FIRST NAME _____

LAST NAME _____

RELATIONSHIP _____

HOME PHONE (_____) _____

WORK PHONE (_____) _____

CELL PHONE (_____) _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

□ Medicare □ Mass Health □ Worker's Compensation □ Commercial □ Other_____

INSURANCE COMPANY _____

INSURED/CARD HOLDER'S NAME _____

RELATIONSHIP _____

POLICY # _____ GROUP # _____

PHONE # (_____) _____

SECONDARY INSURANCE INFORMATION

□ Medicare □ Mass Health □ Worker's Compensation □ Commercial □ Other_____

INSURANCE COMPANY _____

INSURED/CARD HOLDER'S NAME _____

RELATIONSHIP _____

POLICY # _____ GROUP # _____

PHONE # (_____) _____

GUARANTOR / SUBSCRIBER / RESPONSIBLE PARTY

SOCIAL SECURITY #_____

FIRST NAME_____

LAST NAME_____

RELATIONSHIP_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE (_____) _____

DATE OF BIRTH_____/_____/_____

EMPLOYER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

EMPLOYER'S PHONE (_____) _____

RELATIONSHIP_____

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

_____
SIGNATURE (Patient or parent if minor) DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
SIGNATURE (Patient or parent if minor) DATE