Needham Wellesley Family Medicine PC

PATIENT REGISTRATION

Patient Name _____ Date of Birth _____ Sex: M _____ F_____

Address _____ City _____ State _____ Zip Code _____

Please check preferred contact:

Phone: *Home* ❑ _____ *Cell* ❑ _____ *Work* ❑ _____

Social Security Number _____ Email Address _____

Emergency Contact: Name_____ Phone_____ Relationship _____

Are you interested in signing up for Patient Gateway? _____

Primary Language:

❑ English

❑ Other, please specify: _____

Ethnicity:

❑ Hispanic or Latino

❑ Not Hispanic or Latino

❑ Patient Decline

Race:

❑ American Indian or Alaskan Native

❑ Asian

❑ Black or African American

❑ Native Hawaiian or other Pacific Islander

❑ White

❑ Patient Decline

Primary Insurance _____

Name of Policy Holder _____

ID # _____

Date of Birth of Policy Holder _____

Patient's relationship to the insured _____

Secondary Insurance _____

Name of Policy Holder _____

ID # _____

Date of Birth of Policy Holder _____

Patient's relationship to the insured _____

Person responsible for payments not covered by insurance:

❑ Self

❑ Other, please specify name: _____ Phone # _____

Address_____ Relationship_____

Insurance Authorization and Assignment (Please read and sign)

I hereby authorize Needham Wellesley Family Medicine, PC to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to Needham Wellesley Family Medicine, PC for medical services rendered to myself. I understand I am responsible for any amount not covered by insurance, including but not limited to failure to keep scheduled appointments.

Signature _____ **Date** _____