PATIENT INFORMATION

76 Park Street
Attleboro MA 02703
Ph. 508.431.2026
Fax 508.431.2296

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All informaton will be confidential.

Date ______________ Patient Name ______________ (FIRST) ______________ (MI) ______________ (LAST) Patient # ______________

SS #/SIN ______________ ☐ Male ☐ Female Birthdate ______________ Home phone ______________

Address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

E-Mail ______________ Cell phone ______________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent/guardian's employer ______________ Work phone ______________

Business address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Spouse or parent/guardian's name ______________ Employer ______________ Work phone ______________

If patient is a student, name of school/college ______________ City ______________ State/Prov. ______

Whom may we thank for referring you? ______________

Person to contact in case of emergency ______________ Phone ______________

Responsible Party

Name of person responsible for this account ______________ Relationship to patient ______________

Address ______________ Home phone ______________

E-Mail ______________ Cell phone ______________

Driver's license # ______________ Birthdate ______________ Financial institution ______________

Employer ______________ Work phone ______________

Is this person currently a patient at our office? ☐ Yes ☐ No

Insurance Information

Name of insured ______________ Relationship to patient ______________

Birthdate ______________ SS #/SIN ______________ Date employed ______________

Name of employer ______________ Work phone ______________

Address of employer ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Insurance company ______________ Group # ______________ Union or local # ______________

Ins. Co. address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

How much is your deductible? ______ How much have you used? ______ Max. annual benefit? ______

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________ Relationship to patient ______________

Birthdate ______________ SS #/SIN ______________ Date employed ______________

Name of employer ______________ Work phone ______________

Address of employer ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Insurance company ______________ Group # ______________ Union or local # ______________

Ins. Co. address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

How much is your deductible? ______ How much have you used? ______ Max. annual benefit? ______

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X ______________________________ ______________________________

Signature of patient or parent/guardian if minor Date