Emerson Primary Care of Sudbury

NAME:____ DATE OF BIRTH________________________

SEX: ( ) MALE ( ) FEMALE MARITAL STATUS: ( ) S ( ) M ( ) W ( ) DIV LANGUAGE___________________________

ETHNICITY: ( ) CAUCASIAN ( ) BLACK ( ) HISPANIC/LATINO ( ) ASIAN ( ) OTHER ________________________________

ADDRESS:_________________________________CITY:___________________STATE:__________ ZIPCODE:__________

HOME PHONE#:______________________CELL PHONE:______________________ WORK PHONE:__________________

PREFERRED CONTACT: ( ) HOME PHONE ( ) CELL PHONE ( ) WORK PHONE

MAY WE CONTACT YOU AND/OR LEAVE MESSAGES? HOME ( )Y ( )N CELL ( )Y ( )N WORK ( )Y ( )N

WOULD YOU LIKE ACCESS TO OUR PATIENT PORTAL? ( ) YES ( ) NO

EMAIL ADDRESS:____

PRIMARY CARE PHYSICIAN: _____________________________REFERRING PHYSICIAN:__________________________

PHARMACY: _____________________________________MAIL ORDER PHARMACY:______________________________

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**IF YOUR INSURANCE REQUIRES REFERRALS, YOU ARE RESPONSIBLE FOR OBTAINING THEM PRIOR TO YOUR APPOINTMENT, YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR UNAUTHORIZED CARE.

PRIMARY INSURANCE COMPANY (IF CARD NOT COPIED):____

POLICY #:____ GROUP#:____

SUBSCRIBER'S NAME (IF DIFFERENT FROM PATIENT):_________________________________ DATE OF BIRTH:____________

RELATIONSHIP TO PATIENT:__________________________ SUBSCRIBER’S SOCIAL SECURITY#:__________________

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WHOM MAY WE CONTACT IN THE EVENT OF AN EMERGENCY?____

RELATIONSHIP TO PATIENT:_______________________________ PHONE NUMBER________________________________

MAY WE DISCUSS YOUR CONDITION WITH ANY MEMBER OF YOUR FAMILY? ( ) YES ( ) NO

IF YES, WITH WHOM? NAME:_______________________________ PHONE NUMBER:_____________________________

RELATIONSHIP TO PATIENT:________________________________ OTHER(S):_____________________________________

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THIS INFORMATION IS GIVEN FOR THE PURPOSE OF ESTABLISHING AN ACCOUNT AND MEDICAL FILE WITH EMERSON PRIMARY CARE OF SUDBURY. IT IS UNDERSTOOD THAT I SHALL BE RESPONSIBLE FOR ALL CHARGES INCURRED BY ME (OR ANY MINOR CHILD AS NOTED ABOVE). I AUTHORIZE PAYMENT FOR ANY INSURANCE CLAIMS BE MADE DIRECTLY TO EMERSON PRIMARY CARE OF SUDBURY.

PATIENT SIGNATURE:____ DATE:_________________

PATIENT REPRESENTATIVE (MINOR/UNABLE TOSIGN):____

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT:____