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: _______________________________

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: ________________________________

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): ___________________________________

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 TO SIGN): ____

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT: ____

HOW DID YOU HEAR ABOUT US?

- ☐ **INSURANCE**
- ☐ **INTERNET**
- ☐ **FAMILY/FRIENDS**
- ☐ **DOCTOR/E.R. REFERRAL**
- ☐ **OTHER:** ____