

Newton Wellesley Primary Care

Date: _____

Dr. _____

Patient Information

Last Name	First Name	Initial	Sex	Age	Date of Birth
Street Address	City	State		Zip Code	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
Home Phone ())	Employer's Name			Social Security #	
Work Phone ())	Employer's Address				
(name)		(address)		(tel.)	

Person to notify in case of emergency

Billing Address and Name of Responsible Party (If Different)

Last Name	First Name	Initial	Relationship to Patient
Street Address	City	State	Zip Code
Home Phone ())	Employer's Name		
Work Phone ())	Employer's Address		

Insurance

Blue Shield (Mass. Only)	Certificate Number	Subscriber's Name
	Subscriber's Employer	Relationship of Subscriber to Patient
Medicare	Medicare No. _____ - _____ - _____	Letter _____
Medex	Medex No. _____	
Medicaid (Mass. Health)	Recipient Number _____	
	Cardholder's Name _____	

Private Insurance

Private Ins. And Out-of State Blue Shield	Insurance Company	If Out-of-State Blue Shield, Name of State	
	Insurance Company Mailing Address		
	Certificate # / Soc. Security #	Group Name or Number	Plan Name or Number
	Subscriber's Name	Relationship to Patient	

Is There Another Health Benefit Plan?

1. Does your spouse or other family member have health insurance coverage? Yes No
2. Are you covered on this other plan? Yes No

If yes: Subscriber's Name _____
 Relationship to Patient _____
 Insurance Company Name _____
 Insurance Company Address _____
 Certificate # / Social Security # _____
 Group or Plan Name / Number _____

Referred By _____

Reason for this Visit

I hereby authorize Newton Wellesley Primary Care and Dr. Tara Grabowsky, Dr. Liza Meyerhardt, Dr. Kristine Lescinskas/Dulaski, and Dr. Eric Serrano to release information acquired in the course of my treatment to my insurance company. I also authorize direct payment of all services performed/provided by my physician to Newton Wellesley Primary Care and/or Dr. Tara Grabowsky, Dr. Liza Meyerhardt, Dr. Kristine Lescinskas/Dulaski, or Dr. Eric Serrano.

Signed _____ Date _____
 (Parent or Guardian if Minor)