

NEW ENGLAND MEDICAL SPECIALISTS

PATIENT INFORMATION

NAME _____ AGE _____ DOB ___/___/___
ADDRESS _____
CITY _____ STATE _____ ZIP _____
SOCIAL SECURITY # _____ PHONE # _____

SPOUSE'S NAME _____ TEL # _____
IN CASE OF AN EMERGENCY NAME _____
EMERGENCY PHONE # _____
REFERRED BY _____

ANY ALLERGIES _____

EMPLOYMENT INFORMATION

NAME OF EMPLOYER _____ TEL # _____
SPOUSE'S NAME OF EMPLOYER _____ TEL # _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____
SUBSCRIBER _____
PT IDENTIFICATION # _____ GROUP # _____
SECONDARY INSURANCE _____ GROUP # _____
PT IDENTIFICATION # _____ GROUP # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ & SIGN)

I hereby authorize New England Medical Specialist to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical/surgical rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

DATE _____ SIGNATURE _____

MEDICARE PATIENTS ONLY

I request that payments under the Medicare Insurance Program be made directly to New England Medical Specialists on any unpaid bills furnished to me during the period of _____ to _____. I further authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers of insurance companies, any information needed for this authorization to be used in place of the original.

DATE _____ SIGNATURE _____