



BILLERICA MEDICAL & HEALTH CENTER

221 Boston Road Suite 4, Billerica, MA 01862

Phone (978) 670-1300 Fax (978) 670-2890

Patient Registration

Last Name:	First Name:		
Date of Birth:	Age:	Sex: Male <input type="checkbox"/>	Female <input type="checkbox"/>
Social Security Number:	Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/> Widowed <input type="checkbox"/>
Address:			
City:	State:	Zip:	
Home Phone: () -	Work Phone: () -	Extension #:	
Cell Phone: () -	e-mail address:		
Occupation:	Employer (or school):		
Employer's Address:			
In case of an emergency please notify: Name:			
Phone: () -	Relationship:		
Pharmacy used:	Address:	Phone: () -	
How did you hear about us?			

INSURANCE:

Primary Insurance:			
Address of Primary Insurance:			
Phone: () -	Group #:	ID#:	Co-Payment:
Is Patient an Insurance Subscriber: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, relationship to subscriber:			
Secondary Insurance: Name:		Address:	Cert.#

I authorize the release of any medical or other information necessary to process claims. I authorize insurance payments to be made directly to Billerica Medical & Health Center. I understand that I am personally responsible for all deductibles and charges denied by my Insurance. Any lab or incidental charges at this or future visits will be my responsibility. FAILURE TO PROVIDE A 24-HOUR NOTICE OF CANCELLATION OF YOUR APPOINTMENT WILL RESULT IN A \$50 FEE.

Patient Signature: _____ *Date:* _____

RELEASE OF MEDICAL INFORMATION:

I authorize the release of any medical results or other medical information to:

Print Name: _____ Tel # _____ Relationship: _____
Print Name: _____ Tel # _____ Relationship: _____

Patient Signature: _____ *Date:* _____

I have received the Billerica Medical & Health Center Medical Records Privacy Policy (HIPAA.)

Patient Signature: _____ *Date:* _____