NEWTON WELLESLEY SURGEONS INTAKE FORM

Please print clearly and complete all applicable fields.

PATIENT INFORMATION

Name: **Date of Birth:** □ M □ F

Address: **Whom do we thank for referring you to our practice?**

City: **State:** **Zip:**

Home Phone #: **May we leave confidential messages at this number?** □ Y □ N

Cell Phone #: **May we leave confidential messages at this number?** □ Y □ N

SSN: **Marital Status:** □ Married □ Single □ Divorced □ Sep □ Other

Email address: **Would you like to register for the patient portal?** □ Y □ N

Would you like to register for patient satisfaction survey? □ Y □ N

Is there a family member or other individual you authorize us to share your health information with? □ Y □ N

Name: **Phone #** **Relationship:**

Emergency Contact: **Phone #** **Relationship:**

PRIMARY CARE PHYSICIAN INFORMATION

PCP Name: **Phone #** **Fax #**

Address: **City:** **State:** **Zip:**

INSURANCE INFORMATION

Insurance card & photo identification are required.

Primary Insurance Carrier: **Is this a Medicare Replacement Plan?** □ Y □ N

Insurance ID #: **Group # or Employer Name:**

Name of Subscriber: **Date of Birth of Subscriber:**

Secondary Insurance Carrier: **Is this a Medicare Supplement?** □ Y □ N

Insurance ID #: **Group # or Employer Name:**

Name of Subscriber: **Date of Birth of Subscriber:**

INJURY INFORMATION

Are you being seen for an injury? **Check one:** □ Workers Comp □ Auto Accident □ Other Accident

Name of Workers Compensation Insurance Carrier:

Adjuster Name: **Adjuster Phone #:**

Claim #: **Date of Injury:**

Employer Name: **Phone #**

I, the undersigned patient, hereby authorize payment of medical benefits to Newton Wellesley Surgeons, Inc., for any services furnished to me. I understand that I am personally responsible for any charges not covered by my insurance contract. I have received a copy of the Newton Wellesley Surgeons Notice of Privacy Practices prior to provision of service. I have read and agree to comply with the Newton Wellesley Surgeons Financial Policy.

Patient Signature	Print Patient Name	Date
Personal Representative/Parent Signature	Print Personal Representative/Parent Name	Date
Assisted with Form Only / Signature	Assisted with Form Only / Print Name	Date