Newton-Wellesley Surgeons

(617) 244-5355

Welcome. Please print clearly and complete all applicable fields. Please notify us of any changes to this information.

PATIENT INFORMATION				
Name:	Date of Birth:			☐ M ☐ F
Address:	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
Who may we thank for referring you to our practice?				
Do you require any special assistance during your visit to our practice?				
Is there a family member or other individual you authorize us to share your health information with?				☐ Y ☐ N
If so, please complete: Name:	Phone #:		Relationship:	
Emergency Contact Name:	Phone #:		Relationship:	
Do you have a Personal Representative acting on your behalf?				☐ Y ☐ N
PRIMARY CARE PHYSICIAN INFORMATION				
PCP Name:	PCP Phone #:			
PCP Address:	City:	State:	Zip:	
INSURANCE INFORMATION	Insurance card & photo identification are required to file claims.			
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:	Date of Birth of Subscriber:			

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 or individual assisting with completion of this form	Date

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