Reset Form

Merrimack Family Medicine
Lowell General Hospital

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

SSN #: _____-_____-_____ Gender: ___ Male ___ Female Marital Status: _____ Nickname: _____

Email: _____ Race: _____ Language: _____ Ethnicity: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact Preference: _____ Employer: _____ Occupation: _____

How did you hear about us? (*check all that apply)* ____ Facebook/Instagram ____ Online search (Google, Bing, etc.) ____ Yelp

____ Friends/Family ____ Healthgrades/Vitals ____ Practice/Hospital website ____ Other: _____

PHARMACY:

Pharmacy Name: _____ Address: _____

Phone Number: _____ Is this a Mail Order Pharmacy? ____ YES ____NO

INSURANCE INFORMATION:

Insurance Co. Name: _____ Policy Number: _____

Policy Holder's Name: _____ Relation: _____DOB: _____/_____/_____ Sex: ___ M ___ F

Employer: _____ Employer Phone Number:_____

◯ *Check here if address is same as patients or add current Address:* _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____ _____

PARENT/GUARDIAN INFORMATION: (***Fill this Section only if this registration is for a child under 18***)

Last Name: _____First Name: _____ MI: _____ DOB: _____/_____/_____

◯ *Check here if address is same as patients or add current Address*: _____

Home Phone: _____ Cell Phone: _____ Contact Preference: _____

Please hand receptionist all current insurance cards and photo identification once you have completed this form. Co-Payments will be collected at time of visit.

Proudly wellforce