Merrimack Family Medicine
LOWELL GENERAL HOSPITAL

merrimackfamilymedicine.com

600 Clark Road, Ste 3
Tewksbury, MA 01876
Tele: 978-851-4141
Fax: 978-640-9840

Patient Registration

NAME: _____ DOB: _____
(Last) (First) (MI)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ EMAIL : _____ SEX: _____

MARITAL STATUS: _____ SOCIAL SECURITY # _____ RACE: _____

ETHNICITY: _____ LANGUAGE: _____

PRIMARY CARE PROVIDER (PCP) NAME: _____

IN CASE OF EMERGENCY CONTACT NAME: _____

PHONE: _____ RELATIONSHIP: _____

IF PATIENT IS A MINOR PLEASE PROVIDE PARENT/GUARDIAN INFORMATION.

NAME: _____ PHONE: _____ RELATIONSHIP: _____

EMPLOYER: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

MEDICAL INSURANCE INFORMATION

_____
(Company) (Policy #) (Group #) (Cardholder's Name)

_____
(Company) (Policy #) (Group #) (Cardholder's Name)

RELATIONSHIP TO CARD HOLDER: (Please Circle) SELF SPOUSE CHILD OTHER

CARD HOLDER'S EMPLOYER: _____

CARD HOLDER'S DATE OF BIRTH: _____

PARTY RESPONSIBLE FOR PAYMENT: _____
(Name) (Telephone)

_____
(Street) (City) (State) (Zip)

I hereby assign to Merrimack Family Medicine all money to which I am entitled for medical and/or surgical expense relative to the service rendered by them, but not to exceed my indebtedness to them. It is understood that all money received from the above named insurance companies, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand I am financially responsible to said practice for charges not covered by this assignment. ***I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES.***

_____ _____
(Patient, Insured or Guardian Signature) (Date)