

# NEWTON WELLESLEY SURGEONS, INC.

\*Please complete all information below

## 1. Patient Information

Name \_\_\_\_\_ DOB \_\_\_\_\_  M  F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_ Work Ph. \_\_\_\_\_  
SS # \_\_\_\_\_ Marital Status:  Married  Single  Divorced  Widowed

## 2. Physician Information

Primary Care Physician

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_

Referring Physician

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_

It is o.k. to release my medical information to the above Physicians. Initial: \_\_\_\_\_

## 3. Insurance Information - *We must photocopy your insurance card(s)*

Primary Ins. \_\_\_\_\_ Card # \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_ SS # \_\_\_\_\_

Secondary Ins. \_\_\_\_\_ Card # \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_ SS # \_\_\_\_\_

## 4. Other

Workmen's Comp.  Yes  No Auto Accident  Yes  No

Date of Injury or Accident \_\_\_\_\_

## 5. Do you give our practice your permission to speak to a family member about your health care? If so, to whom?

Initial: \_\_\_\_\_

## Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Newton Wellesley Surgeons, Inc. for any services furnished me. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and processing claims.

\_\_\_\_\_  
Patient, Parent or Guardian Signature (if child is under 18 years old)

\_\_\_\_\_  
Date