CSA Commonwealth Surgical Associates

91 Montvale Ave, Suite 208 Stoneham, MA 02180

REGISTRATION-ACKNOWLEDGEMENT-ASSIGNMENT

Patient Information:

Name:
(last name) *(first name)* *(middle initial)*

Address:
(number) *(street)* *(unit/apartment number)*

| Marital Status:
(city) *(state)* *(zip code)* *(m/s/w/d)*

Telephone:
home *(area code/number)* work *(area code/number)* other *(area code/number)*

Date of Birth: / / Age: Sex: SSN: - -
(month) *(day)* *(year)* *(m/f)* *(Social Security Number)*

If Injury: Date of Injury: / / Work related: Auto: Other:
(month) *(day)* *(year)* *(y/n)* *(y/n)* *(y/n)*

In Emergency Notify: ,
(name) *(relationship to patient)*

Telephone:
emergency *(area code/number)* work *(area code/number)* other *(area code/number)*

Policy Holder Information:

Name:
(last name) *(first name)* *(middle initial)*

Address:
(number) *(street)* *(unit/apt)* *(city)* *(state)* *(zip)*

Telephone:
home *(area code/number)* work *(area code/number)* other *(area code/number)*

Birth Date: / / SSN:
(month) *(day)* *(year)* *(Social Security Number)* *(relationship to patient)*

Insurance Information:

Primary Insurance: ,
(insurance carrier name) *(policy holder name)*

Certificate Number: Group Number:

Secondary Insurance: ,
(insurance carrier name) *(policy holder name)*

Certificate Number: Group Number:

Employment Information:

Patient's Employer:

Guarantor's Employer:

Referral Information:

Primary Care Physician:
(name) *(city/town)*

Is Primary Care Physician Referral Required? Referral Number:
(y/n)

Referral Source:
(physician name) *(other source)*

Acknowledgement: I hereby acknowledge receipt of Notice of Privacy Practice of Commonwealth Surgical Associates.

Signature: Date:

Signature of Patient or Authorized Individual:

I hereby assign payment of all insurance benefits to Commonwealth Surgical Associates, P.C. I understand I am Financially responsible for all allowed charges not paid by my insurance and services for which I agreed to pay by Signed waiver.

Signature: Date:

Notice of EMR Data Use and Disclosure Policies:

My signature below certifies that I understand my Electronic Medical Record, with Protected Health Inform, may be viewed by any Physician, Nurse Practitioner or Physician Assistant of Commonwealth Surgical Associates, P.C. and by Reena Tahilramani, M.D., of Winchester Physician Associates. I hereby consent to this sharing of information for treatment of me as a patient. No other sharing of information is covered under this agreement. This agreement is effective from my signature date unless revoked by me in writing.