Charles River Medical Associates, P.C.

Today's Date: _____

Patient Information

Name Last	First	MI	
Other Name	Social Security #	Date of Birth	
Street Address	City	State	Zip Code
Home Phone #	Primary Care Physician	Sex ☐ Male ☐ Female	
Employer Name	Employer Phone #	Marital Status ☐ Single ☐ Married ☐ Other	
Cell Phone	E-Mail		

Responsible Party Information Complete *only* if not Patient

Name	Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent		
Street Address	City	State	Zip Code
Home Phone #	Employer Name		
Work Phone #	Employer Address		

Primary Insurance Information

Insurance Company Name	Insurance Co. Phone #		
Street Address	City	State	Zip Code
Policy #	Group #	Plan #	Date Policy Became Effective
Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent	Subscriber Social Security #		
Subscriber Name	Subscriber Date of Birth		
Subscriber Address	Subscriber Employer		

Secondary Insurance Information

Insurance Company Name	Insurance Co. Phone #		
Street Address	City	State	Zip Code
Policy #	Group #	Plan #	Date Policy Became Effective
Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent	Subscriber Social Security #		
Subscriber Name	Subscriber Date of Birth		
Subscriber Address	Subscriber Employer		

Emergency Contact Information

Emergency Contact Name	Relationship	Home Phone #	Work Phone #

Assignment of Benefits

Authorization to pay benefits to physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described.

_____ _____

Signature of patient or legal guardian Date

Authorization to release information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim.

_____ _____

Signature of patient or legal guardian Date

Lifetime Assignment of Medicare Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to the above referenced Medical Practice for services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of patient or legal guardian Date