

# BURLINGTON MEDICAL ASSOCIATES

Comprehensive Primary, Specialty and Preventive Health Care

## PATIENT REGISTRATION FORM

Patient Name .....

Street Address .....

City ..... State ..... Zip .....

Home Phone ..... Cell Phone .....

Work Phone ..... Usual Provider .....

Patient # ..... Social Security # .....

Date of Birth ..... Sex .....

Marital Status ..... Other Name .....

Email .....

## EMERGENCY CONTACT INFORMATION

Contact Name ..... Home Phone .....

Relationship ..... Work Phone .....

## PRIMARY INSURANCE INFORMATION

Insurance Name ..... Primary Ins. Copay \$ .....

Street Address ..... Subscriber Name .....

City ..... Sub. Address .....

State ..... Zip ..... Sub. City .....

Phone ..... Sub. State ..... Zip .....

Certificate ..... Sub. DOB .....

Group # ..... Sub. SSN .....

Effective Date ..... Sub. Employer .....

Patient Relationship to Subscriber .....

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## SECONDARY INSURANCE INFORMATION

Insurance Name ..... Subscriber Name .....

Street Address ..... Sub. Address .....

City ..... Sub. City .....

State ..... Zip ..... Sub. State ..... Zip .....

Phone ..... Sub. DOB .....

Certificate ..... Sub. SSN .....

Group # ..... Sub. Employer .....

Effective Date ..... Patient Relationship to Subscriber .....

### ASSIGNMENTS 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

.....  
Date

### MEDICARE PATIENTS ONLY 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 to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents, any information needed to determine these benefits or the benefits payable for related services.

.....  
Signature of Patient

.....  
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 the reimbursement for the claim.

.....  
Signature of Patient

.....  
Date

#### FOR OFFICE USE ONLY

Registration Form Signed .....

HIPPA Form Signed .....

Insurance Card Scanned .....

#### BURLINGTON MEDICAL CENTER

790 Boston Road  
Billerica, MA 01821  
Phone: 781-505-8700

#### WOBURN OFFICE

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7 Alfred Street, Suite 320  
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Phone: 781-505-8760