RICHARD A. BARTLETT, M.D., P.C.
77 Pond Avenue, Unit 104C
Brookline, MA 02445
617-735-1800

PATIENT REGISTRATION

PATIENT INFORMATION

Legal Name_____ Date of Birth _____

Preferred Name or Nick Name_____ Age _____

Address_____ Home Phone ( ) _____

City _____ State _____ Zip_____ Cell Phone ( ) _____

Email Address: _____ SS# _____ Sex _____

Would you like to subscribe to our practice email updates and specials? ❑Yes ❑No

Do you participate in online review sites such as Yelp or Healthgrades? ❑Yes ❑No

Employer _____ Occupation _____

Address _____ Phone ( ) _____

City _____ State_____ Zip _____

INSURANCE INFORMATION

Insurance Company _____ Subscriber Name _____

Insurance ID # _____ Subscriber Date of Birth _____

PRIMARY CARE PHYSICIAN

Name _____

Address _____

City_____ State _____ Zip_____

Phone ( ) _____

REFERRED BY

Name _____

Address _____

City_____ State _____ Zip_____

Phone ( ) _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ Home Phone ( ) _____

City_____ State _____ Zip_____ Work Phone ( ) _____

THE FOLLOWING AGREEMENT MUST BE SIGNED BY PATIENT OR PARENT, AND/OR GUARDIANS:
I assume full responsibility for, and agree to prompt and full payment of, all charges incurred by me (or person for whom I am legally responsible).

Signature _____ Today's Date _____