

RICHARD A. BARTLETT, M.D., P.C.

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NEW PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____
Address _____ Home Phone () _____
City _____ State _____ Zip _____ Cell Phone () _____
Email Address: _____ SS# _____ Sex _____

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 _____