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

# 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 ______________________