



233 Ayer Road, Suite 10 • Harvard, MA 01451
(978) 772-0698 • (978) 772-0024 (FAX)
info@HarvardFamilyMedicine.com
HarvardFamilyMedicine.com

Patient Information

Date: _____ How did you hear about us? _____
Last Name: _____ First Name: _____ M.I.: _____
Social Security #: _____ Date of Birth: _____ Gender: M F
Marital Status: Single: Married: Divorced: Widowed: Race: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____
Employer: _____ Occupation: _____
E-Mail Address: _____ Pharmacy and Location: _____

Primary Insurance Information: (Required Information)

Policy Holder Name: _____ Policy Holder SS#: _____
Policy Holder Date of Birth: _____ Policy Holder Employer: _____
Policy Holder Insurance Company: _____

Secondary Insurance Information: (Required Information)

Policy Holder Name: _____ Policy Holder SS#: _____
Policy Holder Date of Birth: _____ Policy Holder Employer: _____
Policy Holder Insurance Company: _____

Spouse's and/or Responsible Party Information: (Required Information)

Name: _____ Social Security #: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell Phone: () _____

In Case of Emergency Please Contact: (Required Information)

Contact Name: _____ Contact Number: _____ Relationship: _____
Nearest Relative Other Than Spouse: _____ Phone Number: () _____

Do You Have a Healthcare Proxy? Y N

Do You Have an Advanced Medical Directive? Y N

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim. I will be bound by this signature as though the undersigned had personally signed the particular claim for me or my dependents.

I hereby authorize the above insurance(s) to pay and hereby assign directly to Harvard Family Medicine all benefits, if any, otherwise payable to me for his/her service as described on the attached forms. I understand I am financially responsible for all changes incurred. I further acknowledge that any insurance benefits, when received by and paid to Harvard Family Medicine will be credited to my account, in accordance with the above assignments.

Authorized Signature of Policy Holder

Patient's Signature

Date