ENHANCED MEDICAL CARE

361 Woodward Street, Newton, MA 02468
Tel: (617) 777-4080 · Fax: (617) 224-4306
E-mail: enhancedmedical@gmail.com

New Patient Registration Form

(1) Patient Information

Last Name: _____ First Name: _____Middle Initial: ____ Suffix: _____

Former Surname: _____ D.O.B.: _____-_____-_____ SSN: _____-_____-_____

Marital Status (please circle): Single Married Engaged Life Partner Divorced Separated Widowed

Home Address: _____

Home phone #: (_____) _____-_____ Home fax #: (_____) _____-_____

Cell phone #: (_____) _____-_____ E-mail: _____

Employer Name: _____

Employer Address: _____

Work phone #: (_____) _____-_____ Work fax #: (_____) _____-_____

(2) Medical Insurance Information

Company or Plan Name: _____ (i.e. BCBS, Tufts, Medicare, Cigna, etc.)

Subscriber or Member ID #: _____ Suffix: _____ (i.e. -00, -01, -10, etc.)

Group #: _____ (Not all plans have this.) Copay amount: OV_____

Are you the primary subscriber (please circle)? Yes No

If not, name of subscriber: _____ Relationship to you: _____

(3) Pharmacy Information

Allergies to Medications (please circle)? Yes No

If yes, please specify: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy phone #: (_____) _____-_____ Pharmacy fax #: (_____) _____-_____

(4) Please return this form by e-mail or fax, along with a copy of the front and back of your insurance card, to Enhanced Medical Care. Thanks and welcome to our practice!