

COMMONWEALTH MEDICAL GROUP

930 Commonwealth Ave. West Boston, MA 02215
617-414-6800 Fax:617-414-6817

Patient Registration

Date ___/___/___

D.O.B.: ___/___/___ SSN: _____ Gender: M/F

Name:
(last) _____ (first) _____ (middle) _____

Address _____ City _____ State _____ Zip Code _____

Phone: _____ Mobile: _____

Marital Status: Single___ Married___ Divorced___ Separated___ Widowed___ Other___

Ethnicity: African-American___ Hispanic___ Asian___ Native American___ White___ Other:___

Employment Status: FT___ PT___ Self-Employed___ Retired___ Student*___ Unemployed___

*If a student or Temporary Resident please provide Home State Mailing Address & Tel No.:

Home State Address _____ City _____ State _____ Zip Code _____

Home telephone: _____

Employer information

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____
Ext: _____

School Name (if student): _____ Full-time___ Part-time___

Personal Contacts (Nearest Legal Relative)

Name (last): _____
(first) _____ (middle) _____

Address: _____

City: _____ State: _____ Zip: _____
Country: _____

Relationship: _____ Phone: _____
Work: _____

Notify in case of Emergency? Y/N

Mother's Name(last): _____ (first): _____

Father's Name (last): _____ (first): _____

Insurance Information

Primary Insurance: _____ State of
Issue: _____

Effective Date: ___/___/___

Insured Party: Self ___ Spouse ___ Parent ___ Other ___

Group #: _____ ID#: _____

Name (insured party): (last) _____
(first) _____ (middle) _____

Insurance
address: _____

City: _____ State: _____ Zip: _____
Country: _____

Phone: _____ Fax: _____ Pre-Approval
#: _____

Secondary Insurance: _____ State of
Issue: _____

Effective Date: ___/___/___

Insured Party: Self ___ Spouse ___ Parent ___ Other ___

Group #: _____ ID#: _____

Name (insured party): (last) _____
(first) _____ (middle) _____

Insurance
address: _____

City: _____ State: _____ Zip: _____
Country: _____

Phone: _____ Fax: _____ Pre-Approval
#: _____