IN ORDER TO UPDATE OUR RECORDS AND TO COMPLY WITH GOVERNMENT RECORD KEEPING STANDARDS, PLEASE COMPLETE THE FOLLOWING:

NAME: ____
(FIRST) (M) (LAST)

DATE OF BIRTH: ________________ **SEX:** ☐ MALE ☐ FEMALE ☐ OTHER ____

ADDRESS: ____

CITY: ____________________ **STATE:** ________ **ZIP CODE:** __________

BILLING ADDRESS (IF DIFFERENT FROM ABOVE):

ADDRESS: ____

CITY: ____________________ STATES: ________ ZIP CODE: __________

RESIDENCE TYPE: ☐ PRIVATE(HOME) ☐ SKILLED NURSING ☐ RESIDENTIAL HOME

HOME PHONE: ____________________ ☐ OK TO LEAVE A MESSAGE?

CELL: ____________________ ☐ OK TO LEAVE A MESSAGE?

WORK: ____________________ ☐ OK TO LEAVE A MESSAGE?

MARITAL STATUS: ____________

OCCUPATION: ______________

EMPLOYER NAME: ______________________________

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ NOT EMPLOYED

WEB ENABLED: ☐ YES ☐ NO

EMAIL ADDRESS: ____________________________________

EMERGENCY CONTACT (REGARDING YOUR CARE):

NAME: ____

ADDRESS: ____

PHONE: ____________ **CELL:** ____________ **WORK:** ____________

RELATIONSHIP: __________________________

RACE:

- ☐ WHITE
- ☐ BLACK / AFRICAN AMERICAN
- ☐ AMERICAN INDIAN / ALASKA NATIVE
- ☐ UNREPORTED/REFUSED TO ANSWER
- ☐ HISPANIC
- ☐ ASIAN
- ☐ OTHER ____________

ETHINICITY:

- ☐ WHITE/NON-HISPANIC
- ☐ AFRICAN AMERICAN
- ☐ HISPANIC
- ☐ OTHER __________
- ☐ REFUSED TO ANSWER

LANGUAGE:

- ☐ ENGLISH
- ☐ SPANISH
- ☐ VIETNAMESE
- ☐ OTHER: ____________

DO YOU NEED AN INTERPRETER AT YOUR VISIT? YES_____ NO _____

** Primary Physician Partners and Partners in Internal Medicine **DO NOT PROVIDE** interpreter services. Please bring someone with you who can understand English who can help you with your health care needs. **

PHARMACY THAT YOU USE REGULARY:

NAME: ____

ADDRESS: ____

MAIL AWAY PHARMACY: ____

DO YOU HAVE AN ADVANCED DIRECTIVE OR HEALTH CARE PROXY? YES_____ NO_____

IF YES, PLEASE MAIL US A COPY FOR OUR FILES.

IF NO, PLEASE COMPLETE THE MASSACHUSETTS HEALTH CARE PROXY FORM AVAILABLE AT OUR FRONT DESK.

PRINT: ____

SIGNATURE: ____

DATE: ____________________________