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

NAME: _____
FIRST MIDDLE INIT. LAST

DATE OF BIRTH_____SEX____M____F

ADDRESS:_____

CITY:_____STATE_____ZIP_____

BILLING ADDRESSIF DIFFERENT FROM RESIDENCE

*STREET*_____

CITY_____STATE_____ZIP_____

PHONE: HOME:_____ ____OKAY TO LEAVE MESSAGE?
WORK:_____ ____OKAY TO LEAVE MESSAGE?
CELL:_____ ____OKAY TO LEAVE MESSAGE?

RESIDENCE TYPE:PRIVATE(HOME)____SKILLED NURSING____RESIDENTIAL HOME____

MARITAL STATUS:_____

EMPLOYER NAME:_____

EMPLOYMENT STATUS:_____FULL TIME_____PART TIME____RETIRED____NOT EMPLOYED

YOU WEB ENABLED WITH OUR OFFICE?____YES____NO_____DECLINE

EMAIL ADDRESS_____

PLEASE LIST A PERSON WE CAN CONTACT OR SPEAK TO REGARDING YOUR CARE:

NAME:_____

ADDRESS:_____

CITY_____STATE_____ZIP_____

PHONE:_____CELL_____WORK_____

RELATIONSHIP TO PATIENT:_____

(PLEASE COMPLETE OTHER SIDE>>>>>)

RACE: _____AMERICAN INDIANOR ALASKA NATINVE _____ASIAN
_____BLACK OR AFRICAN AMERICAM _____HISPANIC
_____NATIVE HAWAIIAN _____WHITE
_____OTHER PACFIC ISLANDER _____OTHER
_____UNREPORTED/REFUSED TO ANSWER

ETHINCITY:_____HISPANIC_____NON-HISPANIC_____REFUSED TO REPORT

LANGUAGE:_____ENGLISH_____SPANISH_____VIETNAMESE_____OTHER_____
DO YOU NEED AN INTERRETER 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 REGULARLY: NAME:_____

STREET:_____CITY_____

MAIL AWAY PHARMACY:_____

DO YOU HAVE AN ADVANCED DIRECTIVE OR HEALTHCARE 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 OU FRONT DESK.

SIGNATURE_____

DATE:_____