Cytogenetics Laboratory
75 Francis Street, Amory 3, Room 151
Boston, Massachusetts 02115
Tel: (617) 732-7981 Fax: (617) 975-0945

PATIENT REGISTRATION & BILLING INFORMATION FORM

Please complete ENTIRE form and fax to: 617-975-0945

PATIENT INFORMATION:

Hospital / Lab Control #

Name: ______________________

Address: ______________________ Sex: ☐ M ☐ F

City,State: ______________________ DOB: / /

Zip: __________ Home Phone: __________ SSN: / /

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed Maiden Name: __________

E.Mail Address: ______________________ Mother's Maiden Name: __________

Primary Care MD: ______________________ Phone: __________

Address: ______________________ City,State,Zip: __________

EMERGENCY INFORMATION:

Name: ______________________ Relationship: ☐ Spouse

Address: ______________________ ☐ Partner ☐ Parent

City,State: ______________________ ☐ Sibling ☐ Grandparent

Zip __________ Daytime Phone: __________ Evening Phone: __________ ☐ Child ☐ Other

EMPLOYER INFORMATION:

Company: ______________________

Address: ______________________

City,State: ______________________

Zip __________ Work Phone: __________

MEDICAL INSURANCE INFORMATION:

Company: ______________________ **Plan Type (HMO/POS/PPO):**

Address: ______________________ **Subscriber #:**

City,State: ______________________ **Member/Group #:**

Zip __________ Phone: __________ **Other Name or #:**

Relationship to Cardholder: __________ Relationship to Guarantor: __________

ORDERING MD INFORMATION:

Ordering MD: ______________________

Institution: ______________________

Address: ______________________

City, State, Zip: __________ E.Mail Address: __________

Phone: __________ Fax: __________ Pager: __________

UPIN #: __________ MA Lic #: __________ Sex: ☐ M ☐ F DOB: / / Specialty: __________

Please send us a copy of the front and back of the patient's medical insurance card.