BWPO d/b/a Department of Surgery
75 Francis Street
Boston, MA 02115
(**T**) 617-732-5282
(**F**) 617-732-6387

MR#:

Name:

DOB:

Patient Registration

Plastic Surgery

Today's Date: _____ ☐ **Patient confirms they have presented their most recent insurance card.**

Patient Information

Name: _____ (Last) _____ (First) _____ (MI)

Address: _____ (Street Name/PO Box) _____ (Apt. Number)

_____ (City) _____ (State) _____ (Zip Code)

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

SS No.: ___ ___ ___-___ ___-___ ___ ___ ___ Birth Date: _____/_____/_____ Male ☐ Female ☐

Married ☐ Single ☐ Other ☐

Patient Status

Employed: _____ (Employer Name) (Address)

Student: Full time: ☐ _____ (School Name) (Address)
Part-time: ☐

Permanent Home Address (if different from Patient Information Section):

_____ (Street Name/PO Box) _____ (Apt. Number)

_____ (City) _____ (State) _____ (Zip Code)

For balance due after insurance, send bill to:

Name: _____ (Parent, Attorney, Guardian, etc.) (_____)_____-_____ (Phone)

Address: _____ (Street Name/PO Box) _____ (Relation)

Primary Care Physician:

Name: _____ (Last) _____ (First)

Address: _____ Phone: (_____)_____-_____

_____ (City) _____ (State) _____ (Zip Code)

Patient Signature

I request that payment of authorized medical benefits be made on my behalf for services rendered. I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents, or any other insurer, any information needed to determine those benefits payable for related services. A copy or system generated printout of this release will be valid as the original form. I acknowledge and agree that I am personally responsible for any co-payments, deductibles, and any balances associated with services I receive that are deemed not covered by my insurance.

→**Sign Here**→ _____
Patient, Parent or Subscriber© Signature