Healthcare South
Scituate Family Practice

56 New Driftway, Suite 203
Scituate, MA 02066
781-544-1388

REGISTRATION

PERSONAL INFORMATION

Name:_____ (First / Last) Date of Birth:____/____/____ (Month / Day / Year)

Social Security #:___-___-____ E-Mail:_____ ☐ Please check for online portal access

Mailing Address:_____ (City / State / Zip)

Primary Phone:___(___)_____ Secondary Phone:___(___)_____

Employer:_____ Occupation:_____

Work Address:_____ (City / State / Zip)

GUARANTOR INFORMATION **complete only if patient is under age 18**

Name:_____ (First / Last) Date of Birth:____/____/____ (Month / Day / Year)

Social Security #:___-___-____

Mailing Address:_____ (City / State / Zip)

Primary Phone:___(___)_____ Secondary Phone:___(___)_____

Employer:_____ Occupation:_____

Work Address:_____ (City / State / Zip)

INSURANCE INFORMATION

Primary Insurance:_____ Secondary Insurance:_____

Policy #:_____ Policy #:_____

Subscriber Name:_____ Relation to patient:_____

EMERGENCY INFORMATION

Emergency Contact:_____ (Name) Phone:_____ (Primary / Secondary)

PHARMACY INFORMATION (if available)

Pharmacy:_____ Phone:_____

AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim and authorize payment of medical benefits to physician.

Signature:_____ Date:_____

Medicare Patients: I understand that my insurance will only pay for services it determines to be reasonable and necessary under section 1862 (a) of the Medicare Law. Your physician (in some cases) may order specific tests to either detect pre-symptomatic diseases, or as part of a process to help determine what the diagnosis is, some insurers, including Medicare, will not pay for the test/exam performed. Medicare does not pay for routine or screening tests. I understand that I will be personally and fully responsible for payment of services not covered by my insurance.

Signature:_____ Date:_____