1030 President Avenue, Suite 305A
Fall River, MA, 02720
Tel: 508.235.6744
Fax:1.888.815.1696

Ocean State Rheumatology

333 School Street, Suite 306
Pawtucket, RI 02860
Tel: 401.205.1100
Fax: 1.888.815.1696

Patient Registration Form

Patient Information

First Name:_____Last Name:_____

Home Address:_____ APT #:_____

City:_____ State: _____ Zip:_____

Email Address:_____ Preferred Language:_____

Social Security #: _____ Date of Birth:_____

Cell:_____ Home Phone:_____

Work:_____

I Authorized Ocean State Rheumatology to send and appointment reminder to me via phone or text message via text message

Gender: [ ] Male [ ] Female Race/Ethnicity: _____ Marital Status: _____

Emergency Contact Information:

First Name:_____Last Name:_____

Phone:_____ Relationship to Patient:_____

Care Team:

Primary Care Physician:_____ Phone #:_____

Referring Physician:_____ Phone #:_____

Other Physicians:_____

Primary Insurance Information:

Insurance Carrier:_____ Policy Type:_____

Member Number: _____ Group Number:_____

Primary Insured First Name:_____ Last Name:_____

Patient Relationship to insured:_____ Date of Birth of Primary Insured:_____

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Patient Registration Form

Secondary Insurance Carrier

Insurance Carrier:_____ Policy Type:_____

Member Number: _____ Group Number:_____

Primary Insured First Name:_____ Last Name:_____

Patient Relationship to insured:_____ Date of Birth of Primary Insured:_____

Preferred Pharmacy Information:

Pharmacy Name:_____Phone:_____

Street Address:_____

City:_____ State: _____ Zip:_____

I hereby consent to the treatment as presribed by my physician and provided by Ocean state Rheumatology Its employees, or re*presentative. I am eligible for the insurance indicated on this form and I understand that Payment is my responsibility regardless of insurance coverage. I understand that i am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill. I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Ocean State Rheumatology for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance. I hereby authorize the release of any and all information to my insurance company or other appropriate party,as required. Pertaining to treatment rendered to my Ocean State Rheumatology.Further, I authorize Ocean State Rheumatology to obtain needed information from physician, employer or insurance company.

Signature of Patient:_____ Date:_____