

Ocean State Rheumatology



Patient Registration Form

1030 President Avenue, Suite 305A
Fall River, MA, 02720
Tel: 508.235.6744
Tel: 401.205.1100
Fax: 1.888.815.1696
Website: www.

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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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 certify that I am the patient or representative of the patient, or an employee of the Arthritis and Rheumatology Institute, its employees, or representative. 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 Arthritis and Rheumatology Institute 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 me by Arthritis and Rheumatology Institute. Further, I authorize Arthritis and Rheumatology Institute to obtain needed information from my physician, employer or insurance company.

Pertainin to treatment rendered to me by Ocean State Rheumatology. Further, I authorize Ocean State Rheumatolgy to obtain needed information from physician, employer or insurance company

Signature of Patient: _____ Date: _____