Please circle answers in indicated fields after printing

PATIENT REGISTRATION

101 Airport Road
Westerly, RI 02891

Daniel R. Gaccione, M.D.
Christopher M. Hutchins, M.D.

489 Rt. 184, Suite 110
Groton, CT 06340

Patient Information:

Name: _____ SS#: _____
Patient Home Address: _____
Patient Sex (Please circle):
Male or Female
City: _____
State: _____ Zip Code: _____
Date of Birth: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Employer Address: _____
Occupation: _____
Work Phone: _____ City: _____
Primary Care Physician: _____ State: _____ Zip Code: _____
Referring Physician: _____ Preferred Pharmacy / Town the Pharmacy is in: _____

Is your condition work related (Please Circle): Yes / No	Workers Comp Claim #: _____
Claims Adjustors Name: _____	Date of Injury: _____

Primary Insurance:

Provider: _____ Group #: _____
Identification or Subscriber #: _____

(Complete the next section if someone other than patient is financially responsible or if you are not primary carrier or insurance)

Relationship to Patient: Spouse, Guardian, Other explain below: _____
Date of Birth: _____ Gender: (Please circle): Male or Female

Secondary Insurance:

Provider: _____ Group #: _____
Identification or Subscriber #: _____
Relationship to Patient: Spouse, Guardian, Other explain below: _____
Date of Birth: _____ Gender: (Please circle): Male or Female

Emergency Contact Information:

Name: _____ Relationship: _____
Contact Number: _____ Cell Phone: _____

I acknowledge that it is my ultimate responsibility to pay for any charges of insurance or other coverage and understand that bills not paid in full within 90 days will be subject to 1 1.5% charge per month. I also agree to pay all responsible costs of collection service and legal fees as well as liens in order to collect monies owed for services by this office. I authorize payment of medical insurance benefits to be made directly to Daniel R. Gaccione, MD / Christopher M. Hutchins M.D. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for all charges not paid by said insurance, to include any procedure that is not covered under my insurance plan.

Signature: _____ Date: _____