

101 Airport Road
Westerly, RI 02891

PATIENT REGISTRATION
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: _____	Date of Birth: _____
State: _____ Zip Code: _____	Cell Phone: _____
Home Phone: _____	Employer Address: _____
Employer: _____	_____
Occupation: _____	City: _____
Work Phone: _____	State: _____ Zip Code: _____
Primary Care Physician: _____	Preferred Pharmacy / Town the Pharmacy is in: _____
Referring Physician: _____	_____

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 #: _____	
<small>(Complete the next section if someone other than patient is financially responsible or if you are not primary carrier or insurance)</small>	
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: _____