33 Lyman St. Suite 400
Westborough, MA. 01581

Phone: 508-898-0055
Fax: 508-898-0035

Patient Registration Form

Patient Name: ______________________________ **Date of Birth**: ____________________

Mailing Address: ____
***We will send Billing Statements, Lab Results and all other correspondence to this address.**

Home Phone# ____________________ **Cell Phone#** ____________________

Gender ❑Male ❑Female ❑ Transgender **Social Security #:** ____________________

Primary Care Provider______________________________ phone#____________________

Email Address: (Please print legibly)

____

By providing your email, you agree to be enabled for our Online Patient Portal

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Who may we discuss your medical information including, account/billing information with?

Name______________________________ contact #____________________
Name ______________________________ contact #____________________

Emergency Contact:
Name: ____________________Phone #: ____________________Relation:______________

Race: ❑White ❑ Asian ❑Black ❑Native Hawaiian ❑American Indian ❑Other: ______________
Ethnicity: ❑Non-Hispanic ❑ Hispanic Origin ❑Unknown
Preferred Language: ❑English ❑ Spanish ❑Chinese ❑Russian ❑Indian ❑Other:______________

<u>Preferred Pharmacies:</u>
Local Pharmacy ______________________________ **Phone:** ______________________________
Mail Order: ______________________________ **Phone:** ______________________________

Do you give us permission to run prescription eligibility? ❑ **Yes** ❑**No**

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, & FINANCIAL RESPONSIBILITY

I authorize CNS and my insurance company to release any PHI information required for processing any insurance claims(s). I also authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for the full amount of the charges which are not covered by insurance benefits. I also understand that CNS submit claims to my insurance company using the information that I have provided for this purpose, and I agree that I will be responsible for the charges if the insurance company indicates that coverage was not in effect. I understand it is my responsibility to verify benefits and coverage with my insurance plan. If being signed by a parent, these provisions apply to the patient named below. If CNS sends me a Billing Statement, payment of the full balance is due within 30 days of the statement date unless I make other formal arrangements with the Billing Department.

Signature____

Printed Name: ______________________________ **Date:** ____________________

PATIENT HISTORY FORM

NAME____ **DATE OF BIRTH**_________________________

Social History

Tobacco Use: ❑Never ❑Current Smoker ❑Former Smoker
Drink alcohol: ❑Never How much and how often? _____________
Substance abuse: ❑Never ❑Currently ❑Former

Please √ each problem that applies to you:

- ❑**Anemia**
- ❑**Anxiety**
- ❑**Arthritis**
- ❑**Cancer:** **state what type** __________________
- ❑**Cataract**
- ❑**Cholesterol**
- ❑**COPD**
- ❑**Coronary Artery Disease**
- ❑**Clotting disorder**
- ❑**Depression**
- ❑**Diabetes**
- ❑**Emphysema**
- ❑**GERD**
- ❑**Glaucoma**
- ❑**Heart Attack**
- ❑**High Blood Pressure**
- ❑**Heart Failure**
- ❑**Heart Murmur**
- ❑**Kidney Disease**
- ❑**Meningitis**
- ❑**Nerve/Muscle Disorder**
- ❑**Osteoporosis**
- ❑**Seizure**
- ❑**Substance Abuse**
- ❑**Stomach Ulcers**
- ❑**Stroke**
- ❑**Tuberculosis**
- ❑**Thyroid Disease**

Please List Previous Surgery:

____
____
____

Please list current Medications below: Indicate Strength and number of times taken daily.

____
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____

Please describe any Allergies: Including reaction

____
____
____

NAME____ DATE OF BIRTH__________________________

Please indicate Family History:

	Mother	Father	sibling	child	Grandmother (maternal/paternal) M/P	Grandfather (maternal/paternal) M/P
Alcohol abuse						
Aneurysm						
Asthma						
Arthritis						
Birth defect						
Breast Cancer						
Colon Cancer						
Other Cancers						
COPD						
Depression						
Diabetes						
Drug Abuse						
Early Death						
Glaucoma						
Heart disease						
Hyperlipidemia						
Hypertension						
Kidney disease						
Seizures						
Mental Illness						
Stroke						
Thyroid disease						
Other						

Please List any other Medical Problems not addressed in this form:

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CNS
ACKNOWLEDGEMENT OF RECEIPT OF PRIVATE PRACTICES

I, ____ acknowledge that I have received a copy
(Name of Patient)

of CNS's Notice of Practices. This notice describes how CNS may use and disclose my protected health information, certain restrictions on the use of disclosure of health information and rights I may have regarding my protected heath information.

____

Signature of Patient or Personal Representative **Date**

____

Relationship to patient