WELCOME TO OUR PRACTICE

MIDDLESEX FAMILY PRACTICE
EMIL YAGUDIN, M.D.
74 MAIN STREET
FRAMINGHAM, MA 01702

No._____

Date (Data):_____

Last Name (Sobrenome):_____Name (Nome):_____

Date of Birth (Date de nascimento):_____Sex (sexo): M___F___

SS# (Social):_____

Marital Status (Estado civil):_____ Number of children (Numero de filho(a))_____

Address(Endereco)_____Apt. #:_____

City (Cidade):_____State (Estado):_____Zip (CEP):_____

Home Phone (Telefone de casa):_____

Mobile#(Celular):_____Email:_____

Occupation (Ocupacao):_____Employed by (Empresa):_____

Business Phone (Telefone da empresa)_____

Whom may we thank for referring you? A quem podemos agradecer pela referencia?

_____

In case of emergency who should be notified? Contato em caso de emergencia:

Name (Nome):_____ Phone (Telefone):_____

I agree that this office will send me emails related to my health. (Eu autorizo esta clinica envie-me emails sobre a minha saude): YES_____ NO____

I agree that this office will call me on my cell phone and/or home phone and leave me a message related to my health. (Eu autorizo esta clinica entrar em contato comigo pelo telefone celular/casa e deixar recado relacionado a minha saude): YES_____ NO_____

ASSIGNEMNT AND RELEASE

THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO DR. YAGUDIN ALL INSURANCE BENEFITS IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFIT. I AUTHORIZE THE USE OF THIS INOFMATION NECESSARY TO SECURE THE PAYMENT OF BENEFIT. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

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Patient's/Guardian's Signature