

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 _____

ASSIGNMENT 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 INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFIT. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Patient's/Guardian's Signature