STEPHEN A. SMITH, M.D.
Massachusetts Eye and Ear Associates, Inc.

PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

PATIENT' S NAME LAST: ____________________ FIRST: ____________________ M.I.: _____

HOME PHONE#: ____________________

STREET ADDRESS: ____________________ WORK PHONE#: ____________________

CITY: ____________________ STATE: _____ CELL PHONE# ____________________

ZIP CODE: ____________ EMAIL: ____________________

MARITAL STATUS (S/M/W/D/O): __________ PRIMARY CARE PHYSICIAN: ____________________

SEX (M/F): _____ PHYSICIAN WHO REQUESTED THIS

DATE OF BIRTH: ____________________ *CONSULTATION*: ____________________

SSN:__________________

PATIENT' S EMPLOYER: ____________________

SUBSCRIBER'S INSURANCE INFORMATION

PRIMARY INSURANCE: ____________________ I.D.#: ____________________

REFERRAL REQUIRED: YES___ NO____ GROUP I.D.#: ____________________

PRIMARY INSURANCE SUBSCRIBER' S NAME: ____________________

SUBSCRIBER' S DATE OF BIRTH: ________________

SUBSCRIBER' S RELATIONSHIP TO PATIENT: ____________________

SUBSCRIBER' S EMPLOYER/CO ____________________ WORK PHONE #: ______________

EMPLOYER' S ADDRESS: ____________________

CITY: ____________________ STATE: ______ ZIP CODE: ________________

SECONDARY INSURANCE (if applicable): ____________________ I.D.#: ____________________

REFERRAL REQUIRED: YES____ NO____ GROUP I.D.#: ________________

SUBSCRIBER' S NAME: ____________________ DATE OF BIRTH: __________________

RELATIONSHIP: __________________

EMPLOYER/CO: ____________________ WORK PHONE#: ________________

EMPLOYER ADDRESS: ____________________

I authorize all insurance benefits relating to services for which I have not paid be assigned to MEEA Associates, Inc. and that medical reports be made available to my referring physician and to my insurance company as needed to facilitate payment.

__________________________ ______________

Signature **Date**

PATREG10.FORM/5-092510