Wellesley Family Care Associates

__ David P. Chodirker M.D ___Alana I Franklin M.D. ___ Jonathan E Snider M.D.
__ Catherine Rea-Lyon M.D. __ Sarah Rosenberg-Scott M.D. ___Nimmi M. Trapasso M.D.
__ Jennifer R Snider FNP

PATIENT REGISTRATION FORM

(Please print clearly)

Last Name _____ **MI** _____ **First Name** _____**DOB** _____

Home Address_____
Street City State Zip

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Preferred phone: Home ___Work___Cell ____ **Email:** _____

Gender: ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other _____	**Primary Language:** ☐ English ☐ Spanish ☐ Vietnamese ☐ Portuguese ☐ Other:_____
Race: ☐ White ☐ Black / African-American ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Other: _____	**Ethnicity:** ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ I do not wish to answer race/ethnicity questions	**Do you need an interpreter?** ☐ Yes ☐ No

Person to contact in case of emergency:

Name _____ **Telephone #** _____

Relationship to patient _____

I authorize the release of any medical information necessary to process insurance claims for reimbursement. I authorize insurance payment to be made directly to my primary care physician.
I understand that I am financially responsible for all charges not covered by my insurance carrier.
I understand the office billing policies. I have read the office Notice Of Privacy Practices according to HIPAA federal regulations.

PATIENT SIGNATURE_____ **Date**_____