CSA Commonwealth Surgical Associates
91 Montvale Ave, Suite 208 Stoneham, MA 02180

REGISTRATION-ACKNOWLEDGEMENT-ASSIGNMENT

Patient Information: *Enter e-mail address*

Name:
(last name) *(first name)* *(middle initial)*

Address:
(number) *(street)* *(unit/apartment number)*

(city) *(state)* *(zip code)* Marital Status: *(m/s/w/d)*

Home Phone: Cell Phone: Work Phone:
home *(area code/number)* work *(area code/number)* other *(area code/number)*

Date of Birth: / / Age: Sex: SSN: Last 4 numbers
(month) *(day)* *(year)* *(m/f)* *(Social Security Number)*

If Injury: Date of Injury: / / Work related: Auto: Other:
(month) *(day)* *(year)* *(y/n)* *(y/n)* *(y/n)*

In Emergency Notify: ,
(name) *(phone)* *(relationship to patient)*

Race: *Circle One:* Asian American Indian or Alaska Native Black Caucasian Pacific Islander Other Decline

Ethnicity: *Circle One:* Hispanic Non-Hispanic Decline **Language**: *Circle One or write-in:* English

Policy Holder Information:

Name:
(last name) *(first name)* *(middle initial)*

Address:
(number) *(street)* *(unit/apt)* *(city)* *(state)* *(zip)*

Telephone:
home *(area code/number)* work *(area code/number)* other *(area code/number)*

Birth Date: / / SSN:
(month) *(day)* *(year)* *(Social Security Number)* *(relationship to patient)*

Insurance Information:

Primary Insurance: ,
(insurance carrier name) *(policy holder name)*

Certificate Number: Group Number:

Secondary Insurance: ,
(insurance carrier name) *(policy holder name)*

Certificate Number: Group Number:

Employment Information:

Patient's Employer:

Guarantor's Employer:

Referral Information:

Primary Care Physician:
(name) *(city/town)*

Is Primary Care Physician Referral Required? Referral Number:
(y/n)

Referral Source:
(physician name) *(other source)*

Acknowledgement: I hereby acknowledge receipt of Notice of Privacy Practice of Commonwealth Surgical Associates.

Signature: Date:

Signature of Patient or Authorized Individual:

I hereby assign payment of all insurance benefits to Commonwealth Surgical Associates, P.C. I understand I am Financially responsible for all allowed charges not paid by my insurance and services for which I agreed to pay by Signed waiver.

Signature: Date:

Notice of EMR Data Use and Disclosure Policies:

My signature below certifies that I understand my Electronic Medical Record, with Protected Health Inform, may be viewed by any Physician, Nurse Practitioner, Physician Assistant or Employee of Commonwealth Surgical Associates, P.C., by my provider and all of
my medical service providers. I hereby consent to this sharing of information for treatment of me as a patient. No other release of