BRIGHAM AND WOMEN'S HOSPITAL

Center for Advanced Molecular Diagnostics
75 Francis Street, Shapiro 5-5054
Boston, Massachusetts 02115
Tel: (857) 307-1500 Fax: (857) 307-1522

PATIENT REGISTRATION & BILLING INFORMATION FORM

Please complete ENTIRE form and fax to: 857-307-1522

PATIENT INFORMATION:

Name: _____ Hospital / Lab Control # _____

Address: _____ Sex: ☐ M ☐ F

City,State: _____ DOB: / /

Zip: _____ Home Phone: _____ SSN: / /

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed Maiden Name: _____

E.Mail Address: _____ Mother's Maiden Name: _____

Primary Care MD: _____ Phone: _____

Address: _____ City,State,Zip: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: ☐ Spouse

Address: _____ ☐ Partner ☐ Parent

City,State: _____ ☐ Sibling ☐ Grandparent

Zip _____ Daytime Phone: _____ Evening Phone: _____ ☐ Child ☐ Other

EMPLOYER INFORMATION:

Company: _____

Address: _____

City,State: _____

Zip _____ Work Phone: _____

MEDICAL INSURANCE INFORMATION:

Company: _____ **Plan Type (HMO/POS/PPO):** _____

Address: _____ **Subscriber #:** _____

City,State: _____ **Member/Group #:** _____

Zip _____ Phone: _____ **Other Name or #:** _____

Relationship to Cardholder: _____ Relationship to Guarantor: _____

ORDERING MD INFORMATION:

Ordering MD: _____

Institution: _____

Address: _____

City, State, Zip: _____ E.Mail Address: _____

Phone: _____ Fax: _____ Pager: _____

NPI #: _____ Specialty _____

Please send us a copy of the front and back of the patient's medical insurance card.