Clear Form

Merrimack Valley Internal Medicine Associates

A CIRCLE HEALTH MEMBER

Complete connected care℠

Primary Care Physician Name _____

Communication Preference (check one): ☐ **Phone**/☐ **Text**/☐ **Patient Portal** (*If Portal, leave email address):* _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

SSN #: _____-_____-_____ Gender: ☐ M ☐ F ☐ T Marital Status: _____ Nickname: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

PHARMACY:

Pharmacy Name: _____ Address: _____

Phone Number: _____ Mail Order Pharmacy_____

INSURANCE INFORMATION:

Insurance Co. Name: _____ Policy Number: _____

Policy Holder's Name _____ DOB: ____/____/____ Sex: ☐ M ☐ F

Relationship: _____ Employer: _____ Employer Phone Number: _____

☐ *Check here if address is same as patients or add current Address*: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

PARENT/GUARDIAN INFORMATION: (***Fill this Section only if this registration is for a child under 18***)

Last Name: _____ First Name: _____ MI: _____ DOB: _____/_____/_____

☐ *Check here if address is same as patients or add current Address*: _____

Home Phone: _____ Cell Phone: _____ Contact Preference: _____

Please hand receptionist all current insurance cards, prescription cards and photo identification once you have completed this form. Co-Payments will be collected at time of visit. Thank You!