# Frank X. Pedlow, Jr., MD, PC

101 Merrimac Street, Suite 250
Boston, Ma., 02114

MGH Blue Card #: _____-_____-_____ Social Security Number: _____-_____-_____
Name: _____ Date of Birth _____/_____/_____Age:_____
Address: _____ City: _____State: _____ Zip: _____
Single: _____ Married:_____ Widowed:_____ Spouse/Companion: _____
Home Phone: (____)_____ Work Phone: (____)_____
Occupation: _____ Employer: _____
Employer Address: _____
In case of emergency notify: _____Phone : (____)_____
Your Primary Care Doctor: _____Phone : (____)_____
Location: _____
The doctor that referred you here: _____Phone : (____)_____
Location: _____

**My physician:** I authorize Frank X. Pedlow, Jr., MD, PC; or their agents to obtain my medical records from other physicians or parties. A photocopy of this form may be used in lieu of the original.

**My Insurance carriers:** I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physician(s). I agree that this authorization will cover all medical services until revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am responsible for the charges that occur as a result of my medical treatment.

_____ _____
Signed (patient or responsible party) Date

## Insurance Information

Primary Insurance Type: _____Policy #: _____
Phone: (____)_____
Secondary Insurance Type: _____Policy #: _____
Phone: (____)_____
Subscriber's name if different from patient: _____
Does your insurance require you to obtain referral's for specialty visits: Yes _____ No _____

***IF YOUR VISTIS ARE TO BE BILLED UNDER WORKERS COMP IF THIS IS A MOTOR VEHICLE ACCIDENT, YOU MUST COMPLETE ALL INOFRMATION.***
***PLEASE BE SURE YOU ARE AUTHORIZED FOR THIS VISIT.***

Injured: ☐ At Work ☐ In A Motor Vehicle Accident
Insurance Company: _____ Claim or File #: _____
Contact Person: _____ Phone: (____)_____
Company Address: _____
Date of accident or work injury: _____

***MEDICAL LIFETIME AUTHORIZATION ( MEDICARE PATIENTS ONLY)***

I authorize any holder of medical or other information about me to release to The Social Security administration and Health Care Financial Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in lieu of the original and request payment of medical insurance benefits whether to myself or to the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signed (patient or responsible party) Date