Frank X. Pedlow, Jr., MD, PC

30 Lancaster Street, 2nd. Floor
Boston, MA 02114
Tel: (617) 227-9300 Fax: (617) 227-3800
www.bostonspinesurgery.com

MGH Blue Card#: ________-_____-_____ Social Security Number: _______-________-__________
Name: ____ Date of Birth____/_____/_____Age: _______
Email Address: _________________________________ Primary Language: ____________________
Address: _______________________________________City: _____________State: ______Zip Code: _______
Home Phone ___________________________________Cell Phone___________________________________
Marital Status: (Circle) Single Married Widowed Spouse/Companion: ____________________
Ethnicity: (Circle) Non-Hispanic Hispanic Prefer Not to Answer ____________________
Race: (Circle) White Hispanic Black Other Prefer Not to Answer
Occupation: ____________________________________ Work Phone: ____________________
Employer Name: _________________________________Address: ____________________
In case of emergency notify: ________________________________Phone: ____________________
Primary Care Doctor: ________________________________Phone: ____________________
Primary Care Doctor's Address / 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 because of my medical treatment.

____ ____________________
Signature (patient or responsible party) Date

Insurance Information

Primary Insurance: ______________________________Policy #: ____________________
Subscriber: ______________________________ Primary Insurance Phone: ____________________
Secondary Insurance: ______________________________Policy #: ____________________
Subscriber: ______________________________ Secondary Insurance Phone: ____________________

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.

____ ____________________
Signature (patient or responsible party) Date