2026 PATIENT REGISTRATION DAVID J. BROWN MD, 700 ATTUCKS LN,1C, HYANNIS, MA 02601 P:508.771.8246 F:508.775.2711

DEMOGRAPHICS: PLEASE PRINT

LAST NAME: _____ FIRST NAME: _____ MI: ____

SEX: *M or F* _____ DATE OF BIRTH _____

ADDRESS: _____ STATE _____ ZIP _____

BILLING ADDRESS: _____

PREFERRED PHONE: _____ ALTERNATE PHONE: _____

EMPLOYER: _____ E-MAIL: _____

RACE: ☐ White ☐ Non-White ETHNICITY: ☐ Hispanic ☐ Non-Hispanic LANGUAGE _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ PARTNER SS# _____

PRIMARY CARE INFORMATION: PLEASE PRINT

NAME OF PCP: _____ PHONE _____ FAX _____

INSURANCE INFORMATION: PLEASE PRINT

PRIMARY INS: MEDICARE OR _____ ID# _____

ADDRESS OF INS: (IF NOT MEDICARE) _____

PHONE OF INS: (IF NOT MEDICARE) _____

SUBSCRIBER OF INS: _____ DOB _____

SECONDARY INS MEDEX OR _____ ID# _____

ADDRESS OF INS: (IF NOT MEDEX) _____

PHONE OF INS: (IF NOT MEDEX) _____

SUBSCRIBER OF INS: _____ DOB _____

PHARMACY LOCATION INFORMATION:

LOCAL: _____ MAIL ORDER: _____

ID# _____

LAB FACILITY USED FOR BLOOD WORK: _____

I HEARBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO DAVID J.BROWN, MD. THIS APPLIES TO ALL INSURANCE CARRIERS, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH/MEDICAL PLAN. I UNDERSTAND THAT IT IS MY RESPONSIBLITY TO REPORT ANY CHANGES IN INSURANCE COVERAGE AND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED.

SIGNATURE: _____ **DATE** _____