UMASS MEMORIAL MEDICAL CENTER CLARK UNIVERSITY HEALTH SERVICES

501 Park Avenue, Worcester, MA Tel: 508-793-7467

PRE-REGISTRATION FORM

Date				E-mail		
Name			Ce	ell Phor	ne#	
Last	First		M.I.			
D.O.B			G	ender:		Pronouns:
,	Preferre	d Language		Race		Ethnicity
Class (circle)			nior Sen		Graduate	
Emergency Contact (Name/Relationship)						Phone
			RANCE INF			
Insurance						
ID#			In	surance	e Address	
City		State	Count	ry		Zip Code
Subscriber's Name			DOB		Relati	onship
Primary Care Physic	cian/Phone Number_					
Do you have another	er insurance? YES	NO				
Pharmacy:						
		CO	ONSENT TO) TRE	AT	
I hereby authorize the patient.	he staff of the Clark U	Jniversity Health S	Service to reno	der suc	h service as m	ay be deemed necessary to the above name
I authorize Clark Un	iversity Health Servi	ces to release info	rmation to an	y hospi	tal or physiciar	I may be referred to by this office.
Memorial Medical C	enter/Clark Universit	y Health Services	authority to c	aim an	y medical insu	any or other payor and assign to UMass rance benefits and payments on the behalf by my insurance and agree to pay for such
PATIENT			WIT	NESS		
DATE			ראם	-=		