Beth Israel Deaconess Medical Center, Boston, MA
OUTPATIENT ONLY LAB REGISTRATION
Important – Use Inpatient Form for all Inpatient Labs

(Please Print)

Medical Record Number:	Account Number:	Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐

Spouse's first name:

Birth Date: / / Sex/Gender: ☐ M ☐ F Street Address: City:

PO Box: Apt or Unit: State/ Country / Zip: / /

Social Security no: - - Home Phone no: ( ) Work Phone: ( )

Other Phone: ( )

Mother's First Name: Father's First Name:

Race/Ethnic Background - Please indicate:

Primary Care Physician (PCP): PCP Phone Number:

PCP Address:

Referring Physician Referring Physician Phone Number:

Next of Kin: Next of Kin Phone:

Next of Kin Address:

EMPLOYMENT & INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Employment Status:	Full Time ☐	Part Time ☐	Not Employed ☐	Self Employed ☐	Retired ☐	Active Military ☐

Person responsible for this bill:

Occupation:

Employer Name and Address:

Insurance Company Name or Plan:

Insurance Billing Address:

Indicate which type of plan: HMO: ☐ PPO: ☐ PFFS: ☐ Other: ☐

Policy Number:

Relationship of Insured: Subscriber ☐ Spouse ☐ Dependent ☐ Other ☐ Indicate -

Name of Insured:

Insurance Start Date:

Is this Group Coverage? Yes ☐ No ☐ If Yes, Group Number:

Additional Insurance

Insurance Company Name or Plan:

Insurance Billing Address:

Indicate which type of plan: HMO: ☐ PPO: ☐ PFFS: ☐ Other: ☐

Policy Number:

Relationship of Insured: Subscriber ☐ Spouse ☐ Dependent ☐ Other ☐ Indicate -

Name of Insured:

Insurance Start Date:

Is this Group Coverage? Yes ☐ No ☐ If Yes, Group Number: