



Raymond Zhou, M.D., P.C.

415 Boston Turnpike, Suite 105
Shrewsbury, MA 01545

Phone: (508) 845-8200
Fax: (508) 845-8300

Patient Registration

Last Name: _____, First Name: _____, Middle _____
Date of Birth: _____, Age: _____, Gender: ___ Male, ___ Female
Marital Status: ___ Single, ___ Engaged, ___ Married, ___ Divorced, ___ Widow, ___ Others
Race: ___ American Indian/Alaska Native, ___ Asian, ___ Black/African American, ___ White
 ___ Native Hawaiian/Pacific Islander, ___ Unknown, ___ Prefer not to answer
Ethnicity of Hispanic/Latino: ___ Yes, ___ No, ___ Unknown, ___ Prefer not to answer
Do you speak English? ___ Yes, ___ No. If no, what language do you speak _____

Home Address: _____
 City: _____ Zip Code: _____
Social Security Number: _____ Cell Phone _____
Home Phone: _____ Work Phone: _____
Email: _____ Occupation: _____
Employer Name/Address: _____
Person to contact in case of emergency: Name: _____
 Phone: _____ Relationship: _____

Primary Insurance: _____
Are you the insurance subscriber? ___ Yes, ___ No.
If no, subscriber Name: _____ Relationship: _____
 Social Security Number: _____, Date of Birth: _____
ID#: _____ Group#: _____ Co-Pay: _____
Secondary insurance if available: _____ ID#: _____

Pharmacy most frequently used: _____ Address: _____

How did you hear about us? ___ Friend/family recommendation, ___ Insurance list, ___ Other:

What made you decide to visit us?
___ Location, ___ Office hour, ___ Dissatisfied with previous doctor, ___ Language,
___ Other: _____

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I hereby authorize Raymond Zhou, M.D., P.C. to release any information necessary to process my insurance claim and direct my carrier to issue payment directly to Raymond Zhou, M.D., P.C. I understand that I am fully responsible for any charges denied by my insurance. I hereby acknowledge that I have received a copy of Notice of Privacy Practices. I also give permission to retrieve my medication usage information to avoid duplication and drug-to-drug interaction.

Patient Signature: _____ Date: _____