Patient Registration Form

Neponset Valley Pediatrics
Boston Children's
Primary Care Alliance

neponsetvalleypediatrics.com
781-784-0403 | *fax* 781-784-0407

Patient information

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ ❍ Male ❍ Female

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Race: _____

Ethnicity: ❍ Not Hispanic, Latino or Spanish origin ❍ Unknown
❍ Hispanic, Latino or Spanish origin ❍ Decline to answer

Needs interpreter: ❍ No ❍ Yes Language: _____

Form confidence: ❍ Very confident ❍ Confident
❍ Not confident ❍ Decline to answer

Visually impaired: ❍ No ❍ Yes

Hearing impaired: ❍ No ❍ Yes

Pharmacy: _____

New primary care physician at Neponset Valley Pediatrics:

_____

Parent/Guardian information

Parent/Guardian #1: _____

Home phone: _____

Can message be left? ❍ Yes ❍ No

Message type: ❍ Brief ❍ Extended

Cell phone: _____

Can message be left? ❍ Yes ❍ No

Message type: ❍ Brief ❍ Extended

Can we text you? ❍ Yes ❍ No

Email: _____

Parent/Guardian #2: _____

Person responsible for bill

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Relation: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Medical insurance information

Copy of insurance card required to file insurance.

Policy holder last name: _____

Policy holder first name: _____

Insurance name: _____

Certificate #: _____

Group #: _____

Member #: _____

Other children

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ ❍ Male ❍ Female

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ ❍ Male ❍ Female

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ ❍ Male ❍ Female

How did you hear of us?

☐ Family/friend ☐ Web search ☐ Social media
☐ Print advertisement ☐ Other

Assignment of benefits and release of information

I hereby authorize my insurance benefits to be paid to Neponset Valley Pediatrics and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Neponset Valley Pediatrics to release information requested concerning my care to insurers paying such benefits.

Signature: _____

Date: _____