Patient Information

Wareham Pediatrics
Boston Children's
Primary Care Alliance
warehampeds.com
508-295-8622

Last Name: _____ First Name: _____ MI: _____
Address: _____Apt. #: _____
City: _____ State: _____ Zip Code: _____
Mailing Address (if different)_____ Apt. #: _____
City: _____ State: _____ Zip Code: _____
Race: _____ Ethnicity: _____ Language: _____
Social Security #: _____ Sex: M☐ F☐ Date of Birth: _____
(circle one)
Home Phone #: _____Can a Message be left: Y☐ N☐Brief or Extended
Cell Phone #: _____ Can a Message be left: Y☐N☐ Brief or Extended
Email Address: _____

Emergency Contact: _____ Phone #: _____
Relationship to patient: _____

Name of person responsible for payment of services: _____
Mother's Full Name: _____ Date of Birth: _____
Mailing Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell phone #: _____
Employer's Name: _____ Phone #: _____
Soc Sec #: _____ Maiden Name: _____

Father's Full Name: _____ Date of Birth: _____
Mailing Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell phone #: _____
Employer's Name: _____ Phone #: _____
Soc Sec #: _____

Insurance Company: _____ Policy #: _____
Effective Date: _____ Policy Holder: _____

Pharmacy: _____ Pharmacy Address: _____

Other Children in the practice: _____
_____

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

Signature: _____ Date: _____