Patient Information

Wakefield Pediatrics
Boston Children's
Primary Care Alliance

wakefieldpedi.com
781-245-2203 | *fax* 781-245-7303

Patient information

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Work phone: _____

Cell phone: _____

Date of birth: _____

Gender: ❑ Male ❑ Female

Parent/Guardian #1 name: _____

Parent/Guardian #2 name: _____

Preferred language: _____

Ethnicity:

❑ Non-Hispanic
❑ Hispanic
❑ Other

Race:

❑ White
❑ Black or African American
❑ Native Hawaiian
❑ Asian
❑ American Indian or Alaska Native
❑ Pacific Islander
❑ Other

Primary insurance information

Insurance name: _____

Policy number: _____

Group/Plan number: _____

Subscriber party name: _____

Subscriber date of birth: _____

Subscriber party address (If different from parent/guardian):

Address: _____

City: _____ State: _____ Zip: _____

Subscriber employer: _____

Secondary insurance information

Insurance name: _____

Policy number: _____

Group/Plan number: _____

Subscriber party name: _____

Subscriber date of birth: _____

Subscriber party address (If different from parent/guardian):

Address: _____

City: _____ State: _____ Zip: _____

Subscriber employer: _____

Assignment of benefits statement

I authorize the release of medical information to process this claim and related claims. I authorize the payment of medical benefits directly to the provider of services. I understand that I am financially responsible for charges not covered by my insurance.

Signature: _____

Date: _____