Patient Registration Form

Lexington Pediatrics
Boston Children's
Primary Care Alliance

lexpeds.com
781-862-4110 | *fax* 781-863-2007

Patient information

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Sex: ❍ Male ❍Female

Address: _____ Apt #: _____

City: _____State: _____

Zip: _____

Race: _____

Ethnicity: _____

Language: _____

Primary care physician: _____

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 #1 name: _____

Parent #2 name: _____

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: _____

Sex: ❍ Male ❍Female

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Sex: ❍ Male ❍Female

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Sex: ❍ 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 Lexington Pediatrics and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Lexington Pediatrics to release information requested concerning my care to insurers paying such benefits.

Signature: _____