Patient Registration Form

Post Road Pediatrics
Boston Children's
Primary Care Alliance

postroadpediatrics.com
978-443-6005 | *fax* 978-443-8429

Patient last name: ____

First name: _________________________________ MI: __________

Date of birth: ____

Address: ____

City: __________________________ State: _____ Zip: _________

Mailing address: (if different from street address)

Address: ____

City: __________________________ State: _____ Zip: _________

Home phone: ____

Patient's cell (If over 14): _____________________________________

Patient email (if over 13): _____________________________________

Race (select one):

❍ Asian ❍ Black/African American
❍ Caucasian ❍ Hispanic
❍ Latino ❍ American Indian or Alaska Native
❍ Pacific Islander ❍ Multiracial ❍ Other

Ethnicity (select one): ❍ Hispanic ❍ Non-Hispanic ❍ Other

Language (select one):

❍ English ❍ Arabic ❍ French
❍ German ❍ Hindi ❍ Mandarin
❍ Spanish ❍ Vietnamese ❍ Other

Gender ❍ Male ❍ Female

Guardian 1 name: ____

Relationship to child: _____________ Date of birth: _____________

Cell phone: ____

Email: ____

Social Security #: ____

Guardian 2 name: ____

Relationship to child: _____________ Date of birth: _____________

Cell phone: ____

Email: ____

Social Security #: ____

Siblings

Name: _________________________ Date of birth: ____________

Name: _________________________ Date of birth: ____________

Name: _________________________ Date of birth: ____________

Emergency contact: ____

Relationship: ___________________ Phone: __________________

Patient's primary care doctor (as listed with insurance company):

____

Preferred pharmacy: ____

Address: ____

City: __________________________ State: _____ Zip: _________

Person responsible for bill: (must be parent/guardian; If 18 or older, or mature/emancipated minor, must be self)

Name: ____

Address: ____

City: __________________________ State: _____ Zip: _________

Phone: ____

Insurance information:

(Patients will be required to show insurance card at all visits)

Primary insurance company: __________________________________

ID#: _____________________ Group #: _____________________

Secondary insurance company: _________________________________

ID#: _____________________ Group #: _____________________

Subscriber's name: ____

Date of birth: ____

Address (If different from above):

____

City: __________________________ State: _____ Zip: _________

Signature: ____

Parent/Guardian name (print): _________________________________

Date: ____