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: _________________ ❍ 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 Lexington Pediatrics:

____

Parent/Guardian information

Parent/Guardian #1: ______________________________________

Home phone: ________________ Cell phone: ________________

Relation: ____

Email: ____

Parent/Guardian #2: ______________________________________

Home phone: ________________ Cell phone: ________________

Relation: ____

Email: ____

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: ___________________________________

Date of birth: ____

Insurance name: ____

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 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: ____