Patient Registration Form

Commonwealth Pediatrics
Boston Children's
Primary Care Alliance

commonwealthpediatrics.com
781-451-0072 | *fax* 781-435-0792

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 Commonwealth Pediatrics:

_____

Parent/Guardian information

Parent/Guardian #1: _____

Home phone: _____ Cell phone: _____

Relation: _____ Email: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Parent/Guardian #2: _____

Home phone: _____ Cell phone: _____

Relation: _____ Email: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Person responsible for bill

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Relation: _____

Home phone: _____ Cell phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

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

Signature: _____

Date: _____