Patient Registration Form

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Westwood 781-326-7700
Mansfield 508-339-9944
Easton 508 535-5535

wmpeds.com

Patient information

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Home phone: _____ Cell phone: _____

E-mail: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Legal sex: ❍ Male ❍ Female ❍ Unknown

Gender identity: ❍ Male ❍ Female ❍ Gender fluid
❍ Transgender male ❍ Transgender female
❍ Other ❍ Will not disclose

Language: _____

Race:
❑ Asian
❑ Black or African American
❑ American Indian or Alaska Native
❑ Middle Eastern or Northern African
❑ Native Hawaiian or other Pacific Islander
❑ White
❑ Other race
❑ Unknown
❑ Will not disclose

Ethnicity:
❍ Hispanic/Latino
❍ Non-Hispanic/Latino
❍ Will not disclose

Primary care physician: _____

Are there any issues with: ❑ Vision ❑ Hearing
that would require services during the visit ?

Parent/Guardian information

Parent/Guardian #1

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Relationship: _____

Legal guardian: ❍ Yes ❍ No

Home phone: _____ Cell phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Parent/Guardian #2

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Relationship: _____

Legal guardian: ❍ Yes ❍ No

Home phone: _____ Cell phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Person responsible for bill

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Medical insurance information

A copy of insurance card is required to file insurance.

Policy holder last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Insurance carrier: _____

ID number: _____

Group number: _____

Claims address: _____

City: _____ State: _____ Zip: _____

Insurance phone number: _____

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Other children

Child #1

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Legal sex: ❍ Male ❍ Female ❍ Unknown

Child #2

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Legal sex: ❍ Male ❍ Female ❍ Unknown

Child #3

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Legal sex: ❍ Male ❍ Female ❍ Unknown

Pharmacy information

Pharmacy name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Assignment of benefits and release of information

I hereby authorize my insurance benefits to be paid to Westwood-Mansfield Pediatric Associates and acknowledge that I am responsible for any balance not covered by those benefits.

I authorize Westwood-Mansfield Pediatric Associates to release information requested concerning my care to insurers paying such benefits.

Parent/Guardian signature (or patient if over 18):

_____

Date: _____

Printed name: _____