Washingtonville Pediatrics
Boston Children's Health Physicians

HEALTHCARE MANDATES REQUIRE ALL PATIENT REGISTRATION INFORMATION FIELDS TO BE COMPLETED:

Date: _____

PARENT INFORMATION

FATHER: _____
(Last Name) (First Name) (Initial)

Home Address: _____

E-Mail: _____

Home Phone: _____ Cell Phone: _____

Employed by: _____

Business Address: _____

Occupation: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

MOTHER: _____
(Last Name) (First Name) (Initial)

Home Address: _____

E-Mail: _____

Home Phone: _____ Cell Phone: _____

Employed by: _____

Business Address: _____

Occupation: _____ Phone: _____

Social Security #: _____ Date of Birth: _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? _____

Address: _____

E-Mail: _____

Phone: _____

PHARMACY INFORMATION

Which pharmacy do you use? _____

Second pharmacy choice? _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Policy Holder Name: _____

Secondary Insurance Name: _____

Policy Holder Name: _____

PLEASE PRESENT INSURANCE CARD EVERY TIME YOU CHECK IN FOR AN APPOINTMENT.

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in or office, we ask that you complete the following questions:

May we leave appointment messages on/with:

Your answering machine?	Yes ____	No ____
Mobile phone?	Yes ____	No ____
Mobile phone text?	Yes ____	No ____
Office Voice Mail?	Yes ____	No ____
With another person?	Yes ____	No ____
Through the mail?	Yes ____	No ____
Via E-Mail?	Yes ____	No ____

May we leave medical information on/with:

Your answering machine?	Yes ____	No ____
Cell phone?	Yes ____	No ____
Mobile phone text?	Yes ____	No ____
Office Voice Mail?	Yes ____	No ____
With another person?	Yes ____	No ____
Through the mail?	Yes ____	No ____
Via E-Mail?	Yes ____	No ____

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list the name(s) and relationship(s) with whom we may discuss this information:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

PHARMACY INFORMATION

Which pharmacy do you use? _____

Second pharmacy choice? _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Policy Holder Name: _____

Secondary Insurance Name: _____

Policy Holder Name: _____

PLEASE PRESENT INSURANCE CARD EVERY TIME YOU CHECK IN FOR AN APPOINTMENT.

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in or office, we ask that you complete the following questions:

May we leave appointment messages on/with:			May we leave medical information on/with:		
Your answering machine?	Yes ____	No ____	Your answering machine?	Yes ____	No ____
Mobile phone?	Yes ____	No ____	Cell phone?	Yes ____	No ____
Mobile phone text?	Yes ____	No ____	Mobile phone text?	Yes ____	No ____
Office Voice Mail?	Yes ____	No ____	Office Voice Mail?	Yes ____	No ____
With another person?	Yes ____	No ____	With another person?	Yes ____	No ____
Through the mail?	Yes ____	No ____	Through the mail?	Yes ____	No ____
Via E-Mail?	Yes ____	No ____	Via E-Mail?	Yes ____	No ____

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list the name(s) and relationship(s) with whom we may discuss this information:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

DEPENDENT INFORMATION:

Patient: ____
(Last Name) (First Name) (Initial)

Date of Birth: ______________________________ Male: ______ Female: ______

RACE:
( ) White
( ) Black/African American
( ) American Indian/Alaska Native
( ) Asian
( ) Native Hawaiian/Pacific Islander
( ) All Other Races
( ) Patient declined to specify/Unknown

ETHNICITY:
( ) Hispanic/Latino
( ) Not Hispanic /Latino
( ) Declined to specify/Unknown
( ) None

PRIMARY LANGUAGE:

COUNTRY:

Patient: ____
(Last Name) (First Name) (Initial)

Date of Birth: ______________________________ Male: ______ Female: ______

RACE:
( ) White
( ) Black/African American
( ) American Indian/Alaska Native
( ) Asian
( ) Native Hawaiian/Pacific Islander
( ) All Other Races
( ) Patient declined to specify/Unknown

ETHNICITY:
( ) Hispanic/Latino
( ) Not Hispanic /Latino
( ) Declined to specify/Unknown
( ) None

PRIMARY LANGUAGE:

COUNTRY:

Patient: ____
(Last Name) (First Name) (Initial)

Date of Birth: ______________________________ Male: ______ Female: ______

RACE:
( ) White
( ) Black/African American
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( ) Not Hispanic /Latino
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PRIMARY LANGUAGE:

COUNTRY: