Patient Registration Form

Post Road Pediatrics
Boston Children's Primary Care Alliance
www.postroadpediatrics.com
978-443-6005 Fax: 978-443-8429

Patient Information

Patient Last name: _____ First name:_____ MI: ___ Date: _____

Date of Birth: _____ Legal Sex: Male Female Unknown

Gender Identity: _____ Pronouns: _____ Preferred name if applicable: _____

Patients Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Patient's Cell (if 13 years or older): _____

Patients email (if 13 years or older):

_____

Mailing Address: **(if different from street address)**

Address: _____

City: _____ State: ____ Zip: _____

Hearing:

Is the patient deaf or do they have serious difficulty hearing?

- Yes
- No
- Choose not to answer

Vision:

Is the patient blind or do they have serious difficulty seeing, even when wearing glasses or contacts?

- Yes
- No
- Choose not to answer

Needs Interpreter: Yes/No **(circle one)**

In what language does the patient/patient's caregiver(s) feel most comfortable **speaking** with a doctor or nurse?

- English
- Arabic
- Brazilian Portuguese
- French
- Haitian Creole
- Japanese
- Korean
- Mandarin
- Portuguese
- Russian
- Spanish
- Vietnamese
- Hebrew
- Other: _____
- Uknown
- Choose not to answer

In what language does the patient/patient's caregiver(s) feel most comfortable **reading** medical or health care instructions?

- English
- Arabic
- Brazilian Portuguese
- French
- Haitian Creole
- Japanese
- Korean
- Mandarin
- Portuguese
- Russian
- Spanish
- Vietnamese
- Hebrew
- Other: _____
- Unknown
- Choose not to answer

Race: (Select all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Middle Eastern or Northern African
- Native Hawaiian or Other Pacific Islander
- White
- Another Race
- Unknown
- Choose not to answer

Ethnicity:

- Yes, of Hispanic, Latino, or Spanish origin
- No, not of Hispanic, Latino, or Spanish origin
- Unknown
- Choose not to answer

Siblings:

Name:_____ Name:_____ Name:_____

Date of birth: _____ Date of birth: _____ Date of birth: _____

Name:_____ Name:_____ Name:_____

Date of birth: _____ Date of birth: _____ Date of birth: _____

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Parental/Guardian Information

Guardian 1 ☐ ☐

Legal Guardian: **Yes/No** (Circle one)
Name: _____
Date of Birth: _____ SSN#_____
Relationship to Child:
☐ Mother ☐ Stepparent
☐ Father ☐ Other _____
Mailing Address:_____
City:_____ State:_____ Zip Code:_____
Cell Phone: _____
Home Phone: _____
Email:_____

Guardian 2 ☐ ☐ ☐ Check if **SAME** address

Legal Guardian: **Yes/No** (Circle one)
Name: _____
Date of Birth: _____ SSN#_____
Relationship to Child:
☐ Mother ☐ Stepparent
☐ Father ☐ Other _____
Mailing Address:_____
City:_____ State:_____ Zip Code:_____
Cell Phone: _____
Home Phone: _____
Email:_____

Emergency Contact (Other than guardians listed above):
Name: _____ Relationship: _____ Primary Phone: _____

Who does the patient primarily reside with?: ☐ Mother ☐ Father ☐ Both ☐ Other:_____

Who is the guarantor/responsible for any medical expenses? Name:_____ Relationship:_____

Which phone number should we list as the primary contact?: _____
Is it ok to leave a message at this number? Yes/No **(circle one)** ☐ ☐

Patient's Pediatrician: _____
Preferred Pharmacy: _____
Address: _____ City: _____ State: _____ Zip: _____

Insurance information: (patients will be required to show insurance card at all visits)

Primary insurance company:_____
ID#:_____Group#:_____
Subscriber's name: _____
Subscriber's date of birth: _____
Subscriber's address:_____
City:_____ State:_____ Zip Code:_____

Secondary insurance company:_____
ID#:_____ Group#:_____
Subscriber's name: _____
Subscriber's date of birth: _____
Subscriber's address:_____
City:_____ State:_____ Zip Code:_____

Form Confidence (for guardians/parents and patients 13+)
Overall, how confident is the patient filling out medical forms on their own?

- ☐ **Very Confident**: Can read, understand, and respond to questions on forms with minimal or no assistance/clarification needed
- ☐ **Confident**: Can read, understand, and respond to questions on forms with occasional assistance/clarification needed
- ☐ **Not Confident**: The patient is completely dependent on support in understanding and filling out medical forms
- ☐ **Choose not to answer/unable to collect/unknown**

How did you hear about us? ☐ Internet search ☐ Social media ☐ Friend/Family ☐ Other:_____

Patient (18+)/Guardian signature:_____
Patient/Guardian name (print):_____ Date:_____