# 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:_____