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: _____

Patient Registration Form

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

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:_____

Financial Policy

Post Road Pediatrics
Boston Children's Primary Care Alliance
postroadpediatrics.com
978-443-6005 | fax 978-443-8429

It is important to us that our relationships with patients and families are not clouded by unclear expectations. For that reason, we want you to completely understand our office financial policy. Please read it carefully before signing.

Prior to your first visit, please verify your child's insurance coverage. If the insurance requires you to choose a Primary Care Physician (PCP), be sure the correct one is listed for your child. If a PCP is required but not listed, the insurance company may deny your claim leaving you responsible for payment. If our doctors do not participate in your plan, you will be responsible for the bill. You should also review your insurance policy for information about referrals, authorizations, procedures, and well visit coverage.

Changes, co-pays and outstanding charges

Please check in at the Front Desk at every visit with your most recent insurance card. Please inform us of any changes to your insurance policy or demographic information. Copays are due and expected at the time services are rendered. We will also ask for payment of any outstanding balance. If you are not covered by insurance, payment is due at the time of service.

Deductibles, co-insurance and unpaid claims

Post Road Pediatrics will bill participating insurances on your behalf. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. We are obligated by our insurance contracts to bill you for deductibles, co-insurance and non-covered balances as dictated by your insurance company. We ask that you help us keep our costs down by making prompt payment.

For your convenience, payments may be made by phone, mail or online via MyChart. We accept most major credit cards, checks, and cash. There is a $25.00 service charge for returned checks.

Well visits with extra services

If, during a well visit, you receive treatment for a medical condition outside the scope of routine preventive care, or a pre-existing problem is addressed in the process of performing your regular well visit, your insurance company may advise us that a copayment is required. If this happens, you will be billed for that copayment or deductible balance.

Referrals and managed care

If you are enrolled in a managed care plan (HMO) you must receive a referral from our office before you see a specialist. Referrals should be requested a minimum of 3–5 days prior to your visit so that your PCP has time to review and authorize each visit. Backdated referrals are not guaranteed. Failure to follow this process may leave you responsible for payment of the charges incurred at the specialist visit.

Missed appointments

We ask that you, whenever possible, notify our office within 24 hours if you are unable to come to a scheduled appointment. Missed appointments represent a cost to our office and may prevent other patients from being seen at that time. For this reason, we reserve the right to charge a fee of $50.00 for a missed or late-cancelled appointment. Excessive abuse of scheduled appointments may result in discharge from our practice.

Please contact our billing office (ext. 194) or the practice manager (ext. 116) if you have any questions.

Agreement

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand and agree that I am responsible for full payment of any non-covered services, medical records fees, returned checks, and missed appointments. I will notify Post Road Pediatrics of any changes to my insurance coverage and contact information.

Responsible party: _____

Relationship to patient: _____

Signature: _____

Date: _____

Policy updated 06/2026