Patient Intake Form

Bridgewater Pediatrics
Boston Children's
Primary Care Alliance

bridgewaterpediatrics.com
508-697-8116 | *fax* 508-697-8117

Patient information

Last name: _____

First name: _____ MI: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Mailing address (if different): _____

City: _____ State: _____ Zip: _____

Home phone: _____

Can a message be left? ❍ Yes ❍ No

Message length: ❍ Brief ❍ Extended

Cell phone: _____

Can a message be left? ❍ Yes ❍ No

Message length: ❍ Brief ❍ Extended

Email address: _____

Social Security #: _____

Gender: ☐ M ☐ F

Date of birth: _____

Race: _____ Ethnicity: _____ Language: _____

Birth hospital: _____

Parent/Guardian #1 name: _____

Previous name (if any): _____

Date of birth: _____

Mailing address: _____

City: _____ State: _____

Zip: _____

Home phone: _____

Cell phone: _____

Employer's name: _____

Employer phone: _____

Social Security #: _____

Parent/Guardian #2 name: _____

Previous name (if any): _____

Date of birth: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Cell phone: _____

Employer's name: _____

Employer phone: _____

Social Security #: _____

Emergency contact: _____

Phone: _____

Relationship to patient: _____

Other children in the practice: _____

_____

Name of person responsible for payment of services:

_____

Pharmacy: _____

Address: _____

Health insurance

Health insurance plan: _____

Policy #: _____ Effective date: _____

Policy holder: _____

Secondary insurance plan: _____

Policy #: _____ Effective date: _____

Policy holder: _____

I hereby authorize my insurance benefits to be paid to Bridgewater Pediatrics and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Bridgewater Pediatrics to release information requested concerning my care to insurers paying such benefits.

Signature: _____ Date: _____