Patient Registration Form

Brookline Pediatrics
Boston Children's
Primary Care Alliance

brooklinepediatrics.com
617-232-2915 | *fax* 617-232-2337

Patient name: _____

Date of birth: _____Gender: _____

Sibling 1 name: _____

Date of birth: _____Gender: _____

Sibling 2 name:_____

Date of birth: _____Gender: _____

Sibling 3 name: _____

Date of birth: _____Gender: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Patient's provider: _____

Race: ❍ White ❍ Asian ❍ Hispanic ❍ African American
❍ Native American ❍ Pacific Islander ❍ Other ❍ Decline

Ethnicity: ❍ Hispanic or Latin American
❍ Non-Hispanic or Latin American ❍ Decline

Primary language: _____

Translator required: ❍ Yes ❍ No

Parent 1: _____

Cell: _____

Email: _____

Date of birth: _____

Address: (❑ same as above) _____

City: _____ State: _____ Zip: _____

Occupation: _____ Work phone: _____

Parent 2: _____

Cell: _____

Email: _____

Date of birth: _____

Address: (❑ same as above) _____

City: _____ State: _____ Zip: _____

Occupation: _____ Work phone: _____

Who is the Guarantor (financially responsible) for patient's account?

Name: _____

Relationship: _____

Date of Birth: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance information (Please fill out completely)

Insurance company and plan type: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber name: _____

Relationship: _____

Subscriber DOB: _____

ID #: _____

Suffix: _____

Group #: _____

Preferred pharmacy: _____

Address: _____

City: _____ State: _____ Zip: _____

MyChart

Parent name: _____

Parent date of birth: _____

Email: _____

ZIP: _____

Child's email (13 years and up): _____

Signature

_____

Date: _____

Print name: _____