Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

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Welcome to our Practice

Patient information

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Gender: ❍ Male ❍ Female ❍ Other

Address: _____ Apt #: _____

City: _____State: _____ Zip: _____

Phone: _____

Email: _____

Race: _____

Ethnicity: _____

Primary language: _____

Primary care physician (PCP): _____

Parent/Guardian information

Parent/Guardian #1 first name: _____

Last name: _____ Date of birth: _____

Address: _____ Apt #: _____

City: _____State: _____ Zip: _____

Phone: _____

Email: _____

Responsible for payment? ❍ Yes ❍ No

Parent/Guardian #2 first name: _____

Last name: _____ Date of birth: _____

Address: _____ Apt #: _____

City: _____State: _____ Zip: _____

Phone: _____

Email: _____

Responsible for payment? ❍ Yes ❍ No

Primary emergency contact

❍ Parent/Guardian #1 ❍ Parent/Guardian #2

❍ Other: _____

Medical insurance

Policy holder last name: _____

Policy holder first name: _____

Insurance name: _____

Group #: _____

Member #: _____

Child #1 last name: _____

Pharmacy: _____

Addreess: _____

Other children

Child #1 last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Gender: ❍ Male ❍ Female ❍ Other

Child #2 last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Gender: ❍ Male ❍ Female ❍ Other

Child #3 last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Gender: ❍ Male ❍ Female ❍ Other

How did you hear about us?

❑ Family/friend ❑ Web search ❑ Social media

❑ Print advertisement ❑ Other

Assignment of benefits and release of information

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

Signature: _____

Date: _____