Hyde Park Pediatrics
Boston Children's
Primary Care Alliance

NEW PATIENT REGISTRATION FORM

Patient's Name and Information

Patient's First: _____ Last: _____ DOB: _____

Permanent Address (# and street): _____ City: _____

State: _____ Zip: _____ Patient cell (if has one): _____

Preferred pharmacy Name/phone/address: _____

Race (check all that apply):

	American Indian or Alaskan Native
	Asian
	Black or African American
	Middle Eastern or North African
	Native Hawaiian or Other Pacific Islander
	White
	Other
	Unknown
	Decline to answer

Is patient of Hispanic, Latino/a/x, or Spanish origin?

	No
	Yes
	Prefer to self-describe
	Prefer not to say

How confident are you that you are filling out this form correctly?

	Confident
	Not confident
	Decline to answer

Primary language of patient? _____ Caregiver? _____ Interpreter needed? _____

Does patient or caregiver have special communication needs due to vision or hearing impairment?_____

Contact Information

	Parent/Guardian #1	Parent/Guardian #2	Other/Emergency Contact
Name			
Relation to patient			
Home phone			
Cell phone			
Work phone			
Email			

Guarantor (main person bringing child to visits and responsible for bills)

Name: _____ DOB: _____Address: _____

Subscriber (person who carries insurance) and insurance info

Name: _____ DOB: _____ Relation to patient: _____

Address (if different than above): _____

Insurance Company Name: _____ PPO/HMO/commercial/self-pay/etc: _____

ID#: _____ Group # _____ Effective Date: _____

How did you hear about us? _____

Signature of Parent or Legal Guardian: _____ Printed Name: _____