Village Pediatrics
Boston Children's
Primary Care Alliance

villagepediatrics.net
508-894-8577

# Patient Information

**CHILD'S LAST NAME** _____ **FIRST NAME** _____**MI** _____

**DATE OF BIRTH** _____ / _____ / _____ **SEX** ☐ M ☐ F **EMAIL** _____

**ADDRESS** _____

**CITY** _____ **STATE** _____ **ZIP CODE** _____

**PCP** _____

**PHARMACY** _____ **ADDRESS** _____

**RACE**

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

☐ Black or African American ☐ White ☐ Hispanic ☐ Refused to Report

**ETHNICITY:** ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refused to Report

**LANGUAGE:** ☐ English ☐ Spanish ☐ Other: _____

**PREFERRED METHOD OF CONTACT:** ☐ Phone ☐ Letter ☐ Both

**HOME PHONE**: _____ **CELL PHONE:** _____

*At which of these phone numbers may we leave a message?* ___Home ___Cell

**PRIMARY INSURANCE NAME**_____ **ID#** _____

**SECONDARY INSURANCE NAME** _____ **ID#** _____

**HOW DID YOU FIND OUT ABOUT OUR OFFICE?** ☐ Family/Friend ☐ Doctor ☐ Hospital ☐ Internet ☐ Facebook

**PARENT/GUARDIAN** (*Full Name*)_____

RELATIONSHIP TO CHILD _____ DATE OF BIRTH _____

SOC. SEC #_____ EMAIL _____

ADDRESS (*If different from child*)_____

**PARENT/GUARDIAN** (*Full Name*)_____

RELATIONSHIP TO CHILD _____ DATE OF BIRTH _____

SOC. SEC #_____ EMAIL _____

ADDRESS (*If different from child*)_____

**EMERGENCY CONTACT** (*Full Name*)_____PHONE #_____

**OTHER CHILDREN IN FAMILY**

Name_____DOB_____ Name_____DOB _____

Name_____DOB_____ Name_____DOB _____

I authorize the release of all medical information necessary to process claims for covered services rendered by Village Pediatrics. I authorize Village Pediatrics to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Village Pediatrics. A copy of this authorization may be used in place of the original. I give permission for Village Pediatrics to obtain my child's medication history from my pharmacy, my health plan(s) and other healthcare providers for the purpose of electronic prescribing and continuity of care.

Signature_____ Date _____