



Ph: 617-491-5111 Fax: 617-491-5222

Patient Registration Form

Patient Information

Last Name: _____

First Name _____ Middle Initial: _____

Date of Birth: _____ Male Female

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Race: _____

Ethnicity: Not Hispanic, Latino or Spanish origin
 Hispanic, Latino, or Spanish origin
 Decline to Answer
 Unknown

Needs interpreter: No Yes Language: _____

Visually Impaired: No Yes

Hearing Impaired: No Yes

New primary care physician at Belmont Cambridge Health Care: _____

Parent/Guardian Information

1. Name: _____

Date of Birth: _____

Home/Cell Phone: _____

Can a message be left? Yes No

Email address: _____

Do you want to sign up for MyChart? Yes No

Employment: _____

2. Name: _____

Date of Birth: _____

Home/Cell phone: _____

Can a message be left? Yes No

Email address: _____

Do you want to sign up for MyChart? Yes No

Employment: _____

Medical Insurance Information

Insurance Name: _____

Policy Holder's Name: _____

Member ID#: _____

Group Number: _____

Main subscriber of the insurance:

Name: _____

Date of Birth: _____ Relation: _____

Address same as above? Yes No

If no, address: _____

How did you hear of us?

- Family/Friend Web search Social Media
 Print advertisement Other

Preferred Pharmacy

Address: _____

City: _____ Zip: _____

Phone: _____

Authorization

I hereby authorize payment for medical treatment by Belmont Cambridge Health Care. I also authorize Belmont Cambridge Health Care to release information as required by other physicians and insurance carriers.

Parent/Guardian signature

Date: _____



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Patient Registration Form

Child's Name: _____

Date of Birth: _____

Person completing this form: _____

Relationship to the patient: _____

Please list all that live at the home with the child: _____

Is your child in daycare or going to be in daycare?

- Yes No

Does anyone in the household smoke?

- Yes No

Prenatal Care

Was your child born full term? Yes No

If no, how premature/early were they? _____

Was your child born vaginally or by C-Section? _____

If C-Section, why? _____

Any complications or concerns during your pregnancy? _____

Family History

Do any close family member(s) have a history (current or in childhood) of any condition or significant health problems? If yes, who? Please describe.

	Yes	No	Who? Please describe
Allergies or Eczema			
Asthma or other breathing problems			
Heart Disease			
Mental Health, Development, Behavioral problems(i.e. depression, ADHD)			
Cancer or blood disorders			
Diabetes			
Other			

Any complications during delivery? _____

Medical History

Medications taken regular/currently: _____

Allergic reactions or intolerance: _____

Any hospitalization besides birth? Yes No

If so, for what? _____

Any serious injuries or illness? If yes, please explain: _____

