Patient Registration Form

Belmont Cambridge Health Care
Boston Children's
Primary Care Alliance
Ph: 617-491-5111 Fax: 617-491-5222

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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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?_____

_____

_____

_____

_____

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:_____

_____

_____

_____

_____

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			