Patient Information Sheet

Father:_____ Date of Birth:_____

Address:_____City:_____State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ SS#:_____

Place of Employment:_____Work Phone:_____

Mother:_____ Date of Birth:_____

Address:_____City:_____State:_____ Zip:_____

Telephone:_____ Cell Phone:_____ SS#:_____

Place of Employment:_____Work Phone:_____

Please circle preferred contact telephone number above. May we leave a voice message? _____

Please note: Automated appointment confirmations are sent to home phone unless otherwise indicated here:_____
As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Emergency Contact Person & Relationship:_____Telephone:_____

Pharmacy:_____ **Address:**_____ **Telephone:**_____

List all children seen in this office: Name:	**DOB:**	**Ins/Member #:**	**Sex:**	**SS #:**	***Please indicate Race – American Indian, Alaskan Native, Asian, Alaskan Native, Asian, Black or African American, White, Hispanic or Other Race:**

Primary Insurance:_____Identification No:_____ Eff. Date:_____
Type of Insurance (please circle): HMO – PPO – POS - Group - Individual – No Insurance

Insurance Address:_____ City:_____State:_____Zip:_____

Subscriber's Name:_____ DOB:_____Relationship to Patient:_____

SS# (If someone other than parent):_____

Secondary Insurance:_____Identification No:_____ Eff. Date:_____
Type of Insurance (please circle): HMO – PPO – POS - Group - Individual – No Insurance

Insurance Address:_____ City:_____State:_____Zip:_____

Subscriber's Name:_____ DOB:_____Relationship to Patient:_____

I authorize release of any medical information necessary to process claims/referrals for the above patients. I also authorize payment directly to my physician. I understand that I am financially responsible for charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

Print Name:_____Relationship:_____

*Requested to comply with the Massachusetts Vaccine for Children Program (VFC) 10/2013