Plymouth Pediatric ASSOCIATES

A Preferred Boston Children's Hospital Primary Care Practice

Please fill out all of the following information.

**Patient's Legal Name**_______________________________ **DOB** __________ Nickname __________

Address ___________________________________________ Gender ________

City ____________________ State _________ Zip _________

Guardian Email ____________________________ **Preferred Language** _______________________

Interpreter needed: Yes☐ No ☐ Low Vision: Yes ☐ No ☐ Hard of Hearing: Yes ☐ No ☐

Main contact number: ____________________________Home ☐ Cell ☐ Work ☐ Other ☐

Patient Cell if 13 + years: ___________________ Patient email if 13+ years: ________________________

Preferred Pharmacy with town/location: ____________________________________________________

**ETHNICITY:** Not of Latino, Spanish **or** Hispanic Origin ☐ Of Hispanic, Spanish or Latino Origin ☐ Decline to answer ☐ unknown ☐

**RACE:** American Indian ☐ Asian ☐ Black or African American ☐ Middle Eastern or Northern African ☐

Native Hawaiian or other Pacific Islander ☐ Some other race ☐ Unknown ☐ White ☐ Decline to answer ☐

**<u>Parent or Guardian Contact Information</u>**

***if more than 2 contacts please use the back of the form ***

| | |
|---|---|
| Name __________________________ | Name __________________________ |
| Relation ___________ DOB _________ | Relation ___________ DOB _________ |
| Phone __________________________ | Phone __________________________ |
| Email __________________________ | Email __________________________ |
| Legal Guardian: __Yes __No | Legal Guardian: __Yes __No |
| Financially Responsible __Yes __No | Financially Responsible __Yes __No |
| Address (if different) ______________ | Address (if different) ______________ |
| ______________________________ | ______________________________ |

**<u>See page 2</u>** ⇨

## Insurance Information

**Primary Insurance** ______________________________ ID # ________________________

Subscriber/Policy Holder name _________________________ Date of Birth ______________

Relation to patient _________________________Primary Care Physician________________

**Secondary Insurance** ____________________________ ID # ________________________

Subscriber/Policy Holder name _________________________ Date of Birth ______________

Relation to patient _________________________

****Additional Children** Other children who are seen at the practice with the **same address & insurance** (if applicable)

Name __________________________ Nickname ____________ DOB __________ Gender _________

Name __________________________ Nickname ____________ DOB __________ Gender _________

Name __________________________ Nickname ____________ DOB __________ Gender _________

Name __________________________ Nickname ____________ DOB __________ Gender _________

Name __________________________ Nickname ____________ DOB __________ Gender _________

Name __________________________ Nickname ____________ DOB __________ Gender _________

**Name of person filling out this form** ________________________________________

**Relation to patient** _________________________ **Today's Date** _________________