Welcome To

Pediatrics West PC

Thank you for choosing our practice. All Information will be STRICTLY CONFIDENTIAL.

Please Print Clearly

Today's Date: _____

Patient's Name: _____ Date of Birth: _____ Sex: M F
(Last) (First) (MI)

Confidential Patient Phone: (13 years +) (_____) _____

Address: _____
(Street or PO Box) (City) (State) (Zip Code)

Mailing Address: _____
(Street or PO Box) (City) (State) (Zip Code)

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Email Address: _____@ _____. _____

PCP Selected (***must notify insurance company of change***): _____

Language:
English ☐
Other: _____
Decline ☐

Race:
Asian ☐ African American ☐
American Indian or Alaska Native ☐
Caucasian ☐ Latino ☐
Multiracial ☐ Other ☐ Decline ☐

Ethnicity:
Hispanic ☐
Non-Hispanic ☐
Other ☐
Decline ☐

GUARDIAN INFORMATION:

Guardian's Name: _____
Relationship to Child: _____
Date of Birth: _____
Work/Cell Phone: (_____) _____

Guardian's Name: _____
Relationship to Child: _____
Date of Birth: _____
Work/Cell Phone: (_____) _____

GUARANTOR: This person assumes responsibility for bills. *Must be parent or guardian*. If 18 or older, mature or emancipated minor, must be self.

Name: _____ Date of Birth: _____

Address: _____
(Street or PO Box) (City) (State) (Zip Code)

Phone: (_____) _____

INSURANCE INFORMATION: (Patients will be required to show insurance card at all visits.)

Primary Insurance Co.: _____ ID/Group: _____Co-Pay $ _____

Secondary Insurance Co.: _____ ID/Group: _____

Subscriber's Name: _____ Date of Birth: _____ Phone: (_____) _____

Address: _____
(Street or PO Box) (City) (State) (Zip Code)

THIS CHILD IS ELIGIBLE FOR THE FEDERAL VACCINES FOR CHILDREN PROGRAM (VFC): Check only one box below:

☐ is enrolled in Medicaid (includes Mass Health and HMO's, etc. if enrolled in Medicaid)

☐ does not have health insurance (check this box if enrolled in Children's Medical Security Plan)

☐ is American Indian (Native American) or Alaska Native

THIS CHILD IS <u>NOT</u> ELIGIBLE FOR THE FEDERAL VACCINES FOR CHILDREN PROGRAM (VFC):

☐ has health insurance and is not American Indian (Native American) or Alaska Native