Demographic Information

Wayland Pediatrics
Boston Children's
Primary Care Alliance

waylandpediatrics.com
508-358-2918 | *fax* 508-358-6054

Parent/Guardian information

Parent/Guardian #1 name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian #2 name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

Patient information

Patient #1 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Patient #2 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Patient #3 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Patient #4 name: _____

Date of birth: _____

American Indian or Alaskan Native: ❍ Yes ❍ No

Preferred pharmacy:

_____

Address: _____

City: _____ State: _____ Zip: _____

Insurance information

Physician listed on insurance policy (if required):

❍ Dr. Ellen Mahoney ❍ Dr. Maya Dor

Insurance company: _____

Address: _____

City: _____ State: _____ Zip: _____

Member ID#: _____

Guarantor's name: _____

Date of birth: _____

Social Security #: _____

Authorization

I hereby authorize payment for medical treatment by Wayland Pediatrics, L.L.C. I also authorize Wayland Pediatrics to release information as required by other physicians and insurance carriers.

Parent/Guardian signature: _____

Date: _____