Patient Registration Form

Belmont Cambridge Health Care
Boston Children's
Primary Care Alliance

belmontcambridgehealthcare.com
617-491-5111 | *fax* 617-491-5222

Patient information

Last name: ____

First name: ______________________________ MI: _________

Date of birth: ____

Address: ____

City: ________________________ State: _____ Zip: _________

Mailing address: (if different from street address)

Address: ____

City: ________________________ State: _____ Zip: _________

Patient phone (If 14+): ______________________ ❍ Cell ❍ Other

Patient email (if 13+): ___________________________________

Race (select one):

❍ Asian ❍ Black/African American
❍ Caucasian ❍ Hispanic
❍ Latino ❍ American Indian or Alaska Native
❍ Pacific Islander ❍ Multiracial ❍ Other

Ethnicity (select one): ❍ Hispanic ❍ Non-Hispanic ❍ Other

Language (select one): ❍ English ❍ Other: ________________

Gender: ____

Family information

Parent/Guardian 1: ____________________________________

Relationship to patient: ___________ Date of birth: ____________

Phone: _________________________________ ❍ Cell ❍ Other

Email: ____

Parent/Guardian 2: ____________________________________

Relationship to patient: ___________ Date of birth: ____________

Phone: _________________________________ ❍ Cell ❍ Other

Email: ____

Emergency contact: ____________________________________

Relationship: ____

Phone: _________________________________ ❍ Cell ❍ Other

MyChart

❍ I would like to sign up for MyChart patient portal access

Pharmacy information

Pharmacy: ____

Address: ____

City: ________________________ State: _____ Zip: _________

Insurance information

Person responsible for bill

Name: ____

Address: ____

City: ________________________ State: _____ Zip: _________

Phone: _________________________________ ❍ Cell ❍ Other

Primary insurance company: ____________________________

Subscriber's name: _______________________________________

Member #: ____

Group #: ____

Secondary insurance company: __________________________

Subscriber's name: _______________________________________

Member #: ____

Group #: ____

Assignment of benefits and release of information

I hereby authorize my insurance benefits to be paid to Belmont Cambridge Health Care and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Belmont Cambridge Health Care to release information requested concerning my care to insurers paying such benefits.

Signature of parent/guardian (or patient if over 18):

____

Name (print): ____

Date: ____