Healthcare South

Hanover Pediatrics

Patient Registration Form page #1

Patient Information:

Last Name: _____ First Name:_____ Middle Name:_____

Street Address:_____ Town:_____ Zip code: _____

Date of Birth:_____Male:_____Female:_____

Phone number:_____Who does the pateint live with:_____

Parent Information:

Parent one: Last Name:_____ First Name:_____Date of Birth:_____

Street Address:_____Town:_____Zip code:_____

Mailing address if different:_____

Cell Phone:_____ Home Phone:_____Work Phone:_____

Email Address:_____ Marital Status:_____

Place of Employment:_____

Parent two: Last Name:_____First Name:_____Date of Birth:_____

Street Address:_____Town:_____Zip code:_____

Mailing address if different:_____

Cell Phone:_____ Home Phone:_____Work Phone:_____

Email Address:_____ Marital Status:_____

Place of Employment:_____

Health Insurance: _____ID Number: _____

Subscriber Name:_____Group number:_____ Start Date:_____

Mail Claim address:_____

Siblings:

Name:_____ Date of Birth:_____

Name: _____Date of Birth:_____

Name:_____Date of Birth:_____

Name:_____Date of Birth:_____

Payment of Benefits:

I authorize payment of benefits as determined by the insurance comapany Directly to Healthcare South. I uinderstand that evenif I authorize payment I may still be responsible for any amounts not paid by my insurance company in the event the charges made are not reasonable and customary.

Signature of Pateint r Legal Guardian:_____ **Date:**_____

Medical Release Authorization:

Insured Party must sign for all claims. Dependent Patient must sign if not minor. I authorize any insurance company , organization, employer hospital physician, dentist or pharmacist to release any information requested wit regard to processing my claim. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature of Patient or Legal Guardian:_____**Date:**_____

Healthcare South

Hanover Pediatrics
Patient Registration Form #2

Under new federal regulations we are required to collect thie following information:

Language: English:_____ Creole:_____
Spanish:_____ French:_____
Other:_____

Race: Unreported/refuse to report:_____
Asian:_____ White:_____
Black/African American:_____
Native Hawaiian:_____ Other Pacific Islander:_____
More than one race:_____
American Indian/Alaska Native:_____

Ethnicity: Hispanic or Latino:_____
Non Hispanic or Latino:_____

Current Medications For Patient:
Medication Name: _____ Dose:_____
Medication Name:_____ Dose:_____
Medication Name:_____ Dose:_____

Allergies for Patient :_____
_____

Patients 13 and older:
Cigaretts: _____ Vaping: _____ Other: _____
Current everyday smoker:_____ Former smoker:_____
Current Some day smoker:_____ Never a smoker:_____
Smoker current status unknown:_____ Unknown if ever smoked:_____

Preferred Method of communication by Doctor/Nurse:
Home Phone:_____ Cell Phone:_____
Work Phone: _____ Declined:_____

For Healthier Lives

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
IMMUNIZATION PROGRAM
VACCINES FOR CHILDREN PROGRAM (VFC)

Patient Eligibility Screening Form

For use in Federally Qualified Community Health Centers

Initial screening

Initial screening date _____ Child's date of birth _____

Child's full name _____

Parent, guardian or legal representative's full name _____

Health care provider's full name _____

Check only one box below:

This child is eligible for immunizations through the federal VFC program because he/she*:

- ☐ is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled in Medicaid)
- ☐ is underinsured (has health insurance that does not pay for vaccinations)
- ☐ does not have health insurance
- ☐ is American Indian (Native American) or Alaska Native

This child is not VFC-eligible because he/she:

- ☐ has health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native American) or Alaska Native

This form must be completed for all children under 19 years old at their initial visit, updated every time a vaccine is given and kept in the child's medical record or on file in the office.

The form may be completed by the parent, guardian, or legal representative, or by the health care provider.

Verification of responses is <u>not</u> required.

*This form identifies which children are eligible for vaccines through the federal Vaccines for Children (VFC) program. If one of the first four boxes in the section above is checked, the child is VFC eligible.

Screening at each subsequent visit (documentation required)

	VFC Eligible				Not VFC Eligible
Date	Is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)	Is underinsured (has health insurance that does not pay for vaccinations)	Does not have health insurance	Is American Indian (Native American) or Alaska Native	Has health insurance