Healthcare South/Cohasset Pediatrics
PATIENT REGISTRATION FORM

Completed by: _____ Date: _____ Time: _____

PATIENT INFORMATON

Last Name: _____ First Name: _____ Middle: _____

Gender: _____ Name patient prefers to be addressed by: _____

Pronoun preference: _____

Street: _____ APT/P.O. Box: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Mobile: _____ Work: _____

Date of birth: _____ Referred by: _____

Primary Care Provider: _____

Email address: (over 18): _____

IF MINOR (UNDER 18)

1st Parent:

First name: _____ Middle _____ Last name: _____

Occupation: _____DOB: _____

Street address: _____ City: _____ State: _____ Zip code _____

Home phone: _____ Mobile: _____ Work: _____

Email: _____

2nd Parent:

First name: _____ Middle _____ Last name: _____

Occupation: _____ DOB: _____

Street address: _____ City: _____ State: _____ Zip code _____

Home phone: _____ Mobile: _____ Work: _____

Email: _____

3rd Legal guardian(s*) (people with the right to make healthcare decisions for the patient, if other than a parent)*

First name: _____ last name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

Email: _____

First name: _____ last name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

Email: _____

With whom does this patient reside?

First name: _____ Middle: _____ Last: _____ Phone: _____

Street address: _____ City: _____ State: _____ Zip code: _____

Email: _____

Who has the legal right to consent to treatment for this patient?

First name: _____ Middle: _____ Last: _____ Phone: _____

First name: _____ Middle: _____ Last: _____ Phone: _____

First name: _____ Middle: _____ Last: _____ Phone: _____

PRIMARY INSURANCE COMPANY INFORMATION

Company Name: _____ Group # _____ Effective date: _____

ID# _____ Co-pay amount: _____

Subscriber Full Name: _____ Gender: _____ DOB: _____

Street: _____ Apt/PO Box: _____

City: _____ State: _____ Zip Code: _____

Insured's employer: _____

Secondary Insurance: _____

EMERGENCY CONTACT (NOT A PARENT)

Name: _____ Phone: _____ Relationship: _____

FAMILY MEMBERS

Last name: _____ First: _____ DOB: _____ Relationship: _____

Last name: _____ First: _____ DOB: _____ Relationship: _____

Last name: _____ First: _____ DOB: _____ Relationship: _____

Last name: _____ First: _____ DOB: _____ Relationship: _____

Last name: _____ First: _____ DOB: _____ Relationship: _____

Last name: _____ First: _____ DOB: _____ Relationship: _____

PATIENT MEDICAL HISTORY

Allergies: _____

Medications: _____

Hospitalizations:

Hospital name: _____ Dates: _____ Reason: _____

Hospital name: _____ Dates: _____ Reason: _____

FAMILY MEDICAL HISTORY

Has anyone in your family had: Cancer yes ____ No ____ heart disease yes ____ no ____ diabetes yes ____ no ____

Tuberculosis yes ____ no ____ Allergies yes ____ no ____ Seizures yes ____ no ____ other serious medical conditions yes ____ no ____ if yes to any, please explain.

Do any parents/aunts/uncles/siblings/grandparents have a history of:

Sudden death yes ____ no ____ asthma yes ____ no ____ food allergies yes ____ no ____ autism yes ____ no ____

Lazy eye yes____ no ____ hearing loss yes ____ no____ developmental delay yes ____ no ____ scoliosis yes ____ no ____

Alcoholism yes ____ no ____ mental illness yes ____ no ____

Other serious illness: _____

OTHER RELEVANT INFORMATION

_____

PAYMENTS OF BENEFITS	**MEDICAL RELEASE AUTHORIZATION**
I authorize payment of benefits as determined by the insurance company directly to: Physician yes ____ no ____ I understand even if I have checked "yes" above I may still be responsible for any amounts not paid by my insurance company in the event charges made are not reasonable and customary. _____ Date: _____ Parent/ legal guardian signature	Insured party must sign for all claims. Dependent patient must sign if not a minor. I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested about processing my claim. I certify the information I furnished is true and correct. I know it is a crime to complete this form with false information or important information is omitted. _____ Date: _____ Parent/legal guardian Signature

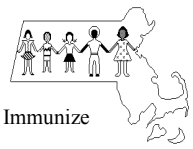
Do both parents/legal guardians authorize the medical providers of this practice to consent to routine and emergency medical care of this patient?

Yes ____ No ____

_____ _____ _____

Signature Date Time

For Healthier Lives



Immunize

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

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