Davis Square Family Practice

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Pediatric

Background Information

Name:_____ **Date of Birth:**_____ **Social Security Number:**_____

Address_____ City_____ State_____ Zip Code_____

Preferred Pronoun:_____

Sex: ☐Male ☐Female **Identifies gender as:** ☐Male ☐Female ☐Self-Described:_____ ☐Choose Not to Disclose

Sexual Orientation: ☐Straight ☐Bisexual ☐Lesbian or Gay ☐Unsure ☐Choose Not to Disclose ☐Self-Described:_____

Siblings (Names/Ages):_____

_____

Allergies_____

Parents' Information

Parent's Name_____ Primary Phone#:_____

Occupation_____ Email: _____

Parent's Name_____ Primary Phone#:_____

Occupation_____ Email: _____

Emergency Contact

Name/Phone#_____ Relation_____

Legal Custody

☐Both Parents ☐One Parent _____ ☐Shared Custody ☐Foster Parent(s):_____

☐Other:_____

Adults in Home (Include Names)

☐Two Parents ☐One Parent with Partner ☐Foster Parent(s) ☐Other:_____

Pharmacy

Name:_____ City/State_____ Phone #:_____

Prescription History Authorization

I grant permission to Davis Square Family Practice to view my prescription history from external sources. ☐**Yes** ☐**No**

Insurance Information

Primary Insurance:_____ Policy Number:_____

Subscriber: ☐Patient ☐Mother ☐Father ☐Other_____ Date of birth of subscriber _____

Secondary Insurance (if applicable)_____ Policy Number:_____

Subscriber: ☐Patient ☐Mother ☐Father ☐Other_____ Date of birth of subscriber _____

Insurance Waiver and Release

I authorize Davis Square Family Practice to furnish any medical information to my insurance carrier(s) concerning myself or my dependents for the purpose of coordination of medical care or benefit determination. I authorize Davis Square Family Practice to receive all payments for medical services rendered to myself or my dependents. I understand I am financially responsible for all amounts uncovered by the insurance carrier(s) and any co-pay due at the time of the visit.

Signature:_____ Date:_____

Self Pay Agreement

I understand that I am financially responsible to pay for any charges incurred by myself or my dependents for medical services provided by Davis Square Family Practice.

Signature:_____ Date:_____

(OVER)

Race: ☐African American ☐Alaskan Native ☐American Indian ☐Asian ☐Black ☐Native Hawaiian ☐Pacific Islander ☐White ☐Other Race ☐Choose Not to Disclose

Hispanic/Latino: ☐Hispanic ☐Non-Hispanic ☐Choose Not to Disclose

Ethnicity: _____

(e.g. Icelandic, Portuguese, African, Asian, Egyptian, Irish, Mexican, etc.)

Primary Written Language: _____ **Religion:** _____

I acknowledge that Davis Square Family Practice has provided me with a copy of *Rules Concerning the Privacy of Your Medical Information* regarding *Protected Health Information* created, received or stored by Davis Square Family Practice. My questions have been answered satisfactorily and I understand this notice.

Parent Signature _____ Date _____

Why are you asking for race, ethnicity, and preferred language?

This information is required under new legislation from the U.S. Department of Health and Human Services (HHS). With the ongoing transition to electronic health records, HHS and our providers will be better able to assess this demographic data in a meaningful way. The goals of these initiatives include improving patient safety and overall healthcare quality. Additionally, we hope to be able to indentify health disparities and better understand and serve all of all patients.

Why are you asking for my email address?

We are now offering our patients easy and private access to their medical information online, so you can view your personal health record whenever and wherever you have access to the internet. You will have access to appointment dates, lab results, x-ray and diagnostic imaging, personal health record and health maintenance reminders. You will also be able to send messages to clinical staff.

You will only be asked for this information once by this office, and you have the right to decline answering these questions.