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: ____

Race: ❍ White ❍ Native Hawaiian or other Pacific Islander
❍ Hispanic or Latino ❍ Black or African American
❍ American Indian or Alaska Native ❍ Decline to answer

Ethnicity: ❍ Not Hispanic, Latino or Spanish origin ❍ Unknown
❍ Hispanic, Latino or Spanish origin ❍ Decline to answer

Patient #2 name: ____

Date of birth: ____

Race: ❍ White ❍ Native Hawaiian or other Pacific Islander
❍ Hispanic or Latino ❍ Black or African American
❍ American Indian or Alaska Native ❍ Decline to answer

Ethnicity: ❍ Not Hispanic, Latino or Spanish origin ❍ Unknown
❍ Hispanic, Latino or Spanish origin ❍ Decline to answer

Patient #3 name: ____

Date of birth: ____

Race: ❍ White ❍ Native Hawaiian or other Pacific Islander
❍ Hispanic or Latino ❍ Black or African American
❍ American Indian or Alaska Native ❍ Decline to answer

Ethnicity: ❍ Not Hispanic, Latino or Spanish origin ❍ Unknown
❍ Hispanic, Latino or Spanish origin ❍ Decline to answer

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: ____

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.

Signature of parent/guardian, or patient if over 18:

____

Date: ____