

# NEPONSET VALLEY PEDIATRICS, PC

450 NORTH MAIN STREET  
SHARON, MA 02067  
781.784.0403

## Patient Information

Date: \_\_\_\_\_ Chart# \_\_\_\_\_

Patient \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Mother/Guardian \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Cell Phone \_\_\_\_\_

Father/Guardian \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Cell Phone \_\_\_\_\_

Sibling \_\_\_\_\_ Sex M \_\_\_ F \_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Sibling \_\_\_\_\_ Sex M \_\_\_ F \_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Sibling \_\_\_\_\_ Sex M \_\_\_ F \_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Children live with: \_\_\_ Mother \_\_\_ Father \_\_\_ Guardian \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Party Responsible for Payment of Medical Services: \_\_\_ Father \_\_\_ Mother \_\_\_ Guardian \_\_\_ Both \_\_\_

How did you hear about our practice? \_\_\_\_\_

## Insurance Information

Primary \_\_\_\_\_ Claims Address \_\_\_\_\_

Policy# \_\_\_\_\_ Group # \_\_\_\_\_ Co-Payment \_\_\_\_\_

Secondary \_\_\_\_\_ Claims Address \_\_\_\_\_

Policy# \_\_\_\_\_ Group # \_\_\_\_\_ Co-Payment \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Relation \_\_\_\_\_

Medicaid/Champus/Other \_\_\_\_\_ Current Card# \_\_\_\_\_

I authorize \_\_\_\_\_ to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to \_\_\_\_\_ for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: \_\_\_\_\_

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Witness' signature \_\_\_\_\_ Date \_\_\_\_\_

I prefer to do my own insurance filing. Signed \_\_\_\_\_ Date \_\_\_\_\_

Complete and sign the next section regarding confidential release information.

**Please complete the following so that we may contact you properly and securely.**

<p>Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations.)</p>	<p>Name _____          Phone _____          Name _____          Phone _____</p>
<p>Please list the family members or significant others, if any, whom we may inform about your child's medical condition <b>ONLY IN AN EMERGENCY.</b></p>	<p>Name _____          Phone _____          Name _____          Phone _____</p>
<p>Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.</p>	<p>_____          _____          _____          _____</p>
<p>Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number. Please be aware that a cell phone is not a secure and private line.</p>	<p>_____          _____          _____          _____</p>
<p>Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL".</p>	<p>Yes or No (circle)</p>
<p>Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?</p>	<p>Yes or No (circle)</p>
<p> </p>	<p> </p>
<p> </p>	<p> </p>

\_\_\_\_\_  
 PATIENT NAME *print* (Parent / Guardian, if under 18 years)

Date: \_\_\_\_\_

\_\_\_\_\_  
 PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Date: \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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To all Neponset Valley Pediatrics Patients:

In order to update our computer system, please answer the following questions:

CHILD'S NAME: \_\_\_\_\_

RACE \_\_\_\_\_

HISPANIC OR NON HISPANIC \_\_\_\_\_

PRIMARY LANGUAGE SPOKEN AT HOME \_\_\_\_\_

CELL PHONE NUMBER \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PHARMACY NAME & LOCATION \_\_\_\_\_

Since the last time your child was here, has he or she been seen by another physician or gone to the emergency room? \_\_\_\_\_