Patient Registration Form

Dr. Jeffrey S. Feldman
Boston Children's
Primary Care Alliance

bostonchildrens.org/alliance/practices/jeffrey-s-feldman
781-662-4560 | *fax* 781-662-4585

Patient name: _____

Date of birth: _____Gender: ❍ Male ❍ Female ❍ Other

Address: _____

City: _____ State: _____ Zip: _____

Patient cell phone: _____

Patient email: _____

Referred by: _____

Race: ❍ White ❍ Asian ❍ Hispanic ❍ African American
❍ Native American ❍ Pacific Islander ❍ Other ❍ Decline

Ethnicity: ❍ Hispanic or Latin American ❍ Other
❍ Non-Hispanic or Latin American ❍ Decline

Primary language: _____

Translator required: ❍ Yes ❍ No

Parent/Guardian 1: _____

Cell phone: _____ Other phone: _____

Email: _____

Date of birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian 2: _____

Cell phone: _____ Other phone: _____

Email: _____

Date of birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Pharmacy: _____

Who is the guarantor (financially responsible) for patient's account?

Name: _____

Relationship: _____ Date of Birth: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance information

Primary insurer: _____

Subscriber name: _____ DOB: _____

Policy or card number: _____

Group number: _____

Employer: _____ Phone: _____

Secondary insurer: _____

Subscriber name: _____ DOB: _____

Policy or card number: _____

Group number: _____

Employer: _____ Phone: _____

Authorization for release of medical information and assignment of benefits

I authorize payments of authorized insurance benefits to Dr. Jeffrey S. Feldman (JSFMDPC).

Health insurance claims are submitted by this office. In the event your insurance company denies your claim, you are responsible for the balance.

I authorize the release of any medical information needed to process my child's/children's claims. I understand that I am financially responsible for all charges whether or not paid by insurance.

All office visit fees are due at the time of service. If applicable, insurance companies will be billed. However, co-payments, deductibles and coinsurances are due at the time of the visit.

JSFMDPC expects full payment within 30 days of the receipt of a bill for services. In cases of financial hardships, we will accept payment plans.

In the event that this account is turned over to an agency for collection of delinquent charges, I agree to pay all costs that are associated with the collection of outstanding charges.

Signature: _____

Date: _____

Printed name: _____

Relationship to patient: _____