New Patient Intake

Walden Pond Pediatrics
Boston Children's
Primary Care Alliance

waldenpondpediatrics.com
978-369-9401 | *fax* 978-371-8810

Patient information

Patient #1 First name: _____

Last name: _____

Date of birth: _____Gender: _____ Race: _____

Primary language: _____

Patient #2 First name: _____

Last name: _____

Date of birth: _____Gender: _____ Race: _____

Primary language: _____

Patient #3 First name: _____

Last name: _____

Date of birth: _____Gender: _____ Race: _____

Primary language: _____

Patient #4 First name: _____

Last name: _____

Date of birth: _____Gender: _____ Race: _____

Primary language: _____

Responsible party information

First name: _____

Last name: _____

❍ Parent ❍ Guardian ❍ Self

Address: _____

City: _____ State: _____ Zip: _____

Mailing address (if different): _____

City: _____ State: _____ Zip: _____

Phone: _____ ❑ Preferred
❍ Home ❍ Office ❍ Cell ❍ Other

Phone: _____ ❑ Preferred
❍ Home ❍ Office ❍ Cell ❍ Other

Phone: _____ ❑ Preferred
❍ Home ❍ Office ❍ Cell ❍ Other

Marital status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated

Employer: _____

Employer address: _____

City: _____ State: _____ Zip: _____

How did you learn about the practice? _____

Primary insurance

Insurer: _____

Policy/ID #: _____

Group #: _____

Policy holder name: _____

Relationship to patient: _____

SSN: _____ Date of birth: _____

Secondary insurance (if applicable)

Insurer: _____

Policy/ID #: _____

Group #: _____

Policy holder name: _____

Relationship to patient: _____

SSN: _____ Date of birth: _____

Tertiary insurance (if applicable)

Insurer: _____

Policy/ID #: _____

Group #: _____

Policy holder name: _____

Relationship to patient: _____

SSN: _____ Date of birth: _____

NEXT PAGE >

Emergency contact information

Contact #1 First name: _____

Last name: _____

Relationship to patient: _____

Phone: _____ ❑ Preferred

❍ Home ❍ Office ❍ Cell ❍ Other

Phone: _____ ❑ Preferred

❍ Home ❍ Office ❍ Cell ❍ Other

Contact #2 First name: _____

Last name: _____

Relationship to patient: _____

Phone: _____ ❑ Preferred

❍ Home ❍ Office ❍ Cell ❍ Other

Phone: _____ ❑ Preferred

❍ Home ❍ Office ❍ Cell ❍ Other

Assignment and release

I hereby authorize payment directly to Walden Pond Pediatrics, PC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize Dr. Bakshi and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: _____

Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian name: _____

Relationship to patient: _____

NEXT PAGE >