Bramblebush Pediatrics
Boston Children's
Primary Care Alliance

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508-548-6969 | fax 617-730-7995
bramblebushpediatrics.com

Childs Name: ______________________ Date of Birth: ____________ Sex: M / F

Mailing Address: ______________________ City: ______________ State: ________

Home Phone # ______________________ Patient Phone # ______________________

Patient E-Mail: (13 years or Older) ______________________________

Patient Primary Language: ______________________

Patient Lives With: (Please Circle One) Both Parents Mother Father Other______________

Mothers Name: ______________________ DOB:__________ Cell # ______________

Home Address: (If Different) ______________________ Work # ______________

E-Mail: ______________________________

Fathers Name: ______________________ DOB:__________ Cell # ______________

Home Address: (If Different) ______________________ Work # ______________

E-Mail: ______________________________

Siblings Names: ______________________ ______________________

______________________ ______________________

Emergency Contact: (Other than Parent) ______________________________

Relationship to Patient: ______________________ Phone # ______________________

Preferred Pharmacy: ______________________ Locations: ______________________

Guarantor: (Who Will Receive Bills or Any Insurance Information) ______________________

Primary Insurance: ______________________ Policy # ______________________

Subscriber: ______________ Subscriber DOB: __________ Relationship to Patient: ________

Secondary Insurance: ______________________ Policy # ______________________

Subscriber: ______________ Subscriber DOB: __________ Relationship to Patient: ________

Personal Preference Information

By answering the following questions, our office will provide better care for you and appropriately address you with respect and the best communication possible. **We understand that the gender information may not apply to some patients based on age.** We appreciate you providing any information that would help us give you the best possible care.

Patients Legal Name: ______________________________ DOB: ____________________ Legal Sex:____________

Patients chosen Name to be addressed as:____

Gender Information

Sex assigned at Birth: (Please Circle)

Choose not to Answer Female Male Not Recorded at Birth Uncertain Unknown

Gender Identified With: (Please Circle)

Choose not to Answer Female Male Not Recorded at Birth Uncertain Unknown

Gender Pronoun: (Please Circle)

Him / He She / Her Them or They

Impairing (Circle all that Apply)

Low Vision: Child Mother Father Guardian
Hearing Impaired: Child Mother Father Guardian

Language Preferences (Please Circle)

Spoken Language: Brazilian Portuguese Croatian English German Haitian Creole Korean Mandarin Polish Portuguese Russian Spanish Ukrainian Unknown Vietnamese Other______

Written Language: Brazilian Portuguese Croatian English German Haitian Creole Korean Mandarin Polish Portuguese Russian Spanish Ukrainian Unknown Vietnamese Other______

Would you like to use an Interpreter service when you visit the office ? Yes No Unknown

What Race do you identify as ? American Indian / Alaskan Native Asian Black / African American Decline to Answer Middle Eastern / North African Native Hawaiian / Pacific Islander Some other Race Unknown Race White

Which Ethnicity do you identify as: Decline to Answer Not Hispanic, Latino or Spanish Origin Hispanic, Latino or Spanish Origin Unknown

Please Indicate the Patient's Form of Confidence: Confident Not Confident Very confident Decline to Answer