Welcome to Pediatrics

MR# ____________

In order to serve you promptly, we need the following information. Fill out each item or put not applicable (N/A).

Office Use Only

Check here if Notice of Privacy Policy is on file: ☐ Check here if consent form is on file: ☐

Is the patient: New ☐ Established ☐ Original registration date: ____________ *(month/day/year):*

Patient General Information

Patient Last Name: ____________ First Name: ____________ Middle Initial: ______

Mailing Address: ____________ City: ________ State: ________ Zip Code: ________

Date of Birth: ________ Sex: ☐ Male ☐ Female Social Security #. ☐☐☐-☐☐-☐☐☐☐

Home Phone: ____________ Ok to call? ☐ Yes ☐ No Other phone: (ex: cell, pager) ____________

Are you Homeless? ☐ Yes ☐ No

How do you describe yourself? *(check one box)*

- ☐ White / Non-Hispanic
- ☐ Black / Non-Hispanic
- ☐ Hispanic
- ☐ Asian / Pacific Islander
- ☐ American Indian
- ☐ Alaskan Native
- ☐ Don't Know
- ☐ Other Specify: ____________

In what country were you born? ____________ What language do you speak most often? ____________

What is your Ethnicity/Ancestry?

- ☐ African
- ☐ African American
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Central American
- ☐ Chinese
- ☐ Colombian
- ☐ Dominican
- ☐ European
- ☐ Haitian
- ☐ Laotian/Hmong
- ☐ Middle Eastern
- ☐ Other Asian ____________
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ White
- ☐ Don't Know
- ☐ Other – Specify: ____________

Parent / Guardian Information

Parent/Guardian Last Name: ____________ First Name: ____________ Middle Initial : ______

Parents Employment Status *(check one)*: Full Time ☐ Part Time ☐ Seasonal ☐ Migrant ☐ Unemployed ☐

Employer Name: ____________ Work Phone: ____________ Ok to Call? Yes ☐ No ☐

____________ City: ________ State: ______ Zip Code: ________

Names of other Children

Last Name	First Name	Middle Initial	Date of Birth

Emergency contact Information

Emergency Contact Name: ____________ Emergency Phone Number: ____________

Relationship to Patient: ____________ Other Phone (Cell, Pager, Etc.): ____________

Mother's Name ____________ Mothers D.O.B ________ Father's Name ____________ Fathers D.O.B ________

Insurance Information

Do you have Healthcare Coverage? *(check one)*: Yes ☐ No ☐

If you answered NO, would you like to speak to a financial counselor to apply for assistance? Yes ☐ No ☐

Insurance Name: ____________ Are you also insured by MassHealth/Medicaid? ☐ Yes ☐ No

Policy # ____________ Group # ____________

Subscribers Name: ____________ Address: ____________

Insurance Telephone: ____________ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Rev 8.3

Lowell Community Health Center
Consent

Patient Name:________________________ **Medical Record#:**____________

(I) Consent to treat:

I hereby authorize Lowell Community Health Center and all its included departments to render any health services and treatment that is deemed necessary, to me in accordance with the policies and procedures of the Health Center. I understand that I retain the right to refuse any or all of the recommended treatment.

(II) Consent to Share Medical Records:

I understand that my medical record information could be shared within the different departments of the Lowell Community Health Center. The information will be shared only to help in my health care assessment and management.

(At the present time the departments under Lowell Community Health Center include Pediatric Services/Adult Services/Women's Services/Prenatal Services/Addiction Treatment Services/Metta Health Center/HIV Treatment Services/STD services and School Health. Additional departments may be added in the future.)

I also understand that at any time during the course of my medical treatment, a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

I hereby authorize Lowell Community Health Center to release my medical records to be reviewed for the purposes of an Audit and/or Evaluation. (The purpose of this review is to enhance patient care and to comply with managed care requirements). I understand that no identification of my name or address will be recorded during this review process.

(III) Confidentiality:

I understand that the Lowell Community Health Center adopts a very strict policy regarding privacy and confidentiality of my medical information. I have been given the privacy and confidentiality statement of the Health Center and have reviewed the information.

(IV) Medical Insurance Authorization and Assignment:

I hereby authorize Lowell Community Health Center and all its included entities to furnish information to my insurance carriers concerning my illness and treatments. I hereby also assign to the Provider(s) and/or Lowell Community Health Center, all the payments for the medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

I understand that this consent in its entirety will remain in effect as long as I continue to receive health care services at Lowell Community Health Center.

Privacy/Confidentiality Statement Given to Patient   Health Proxy offered

____________________________   ____________________________

Signature of the Patient   Date

____________________________   ____________________________

Signature of Parent/Guardian   Signature of Witness

[illegible]