Today's Date:_____

Framingham Pediatrics
Demographics Form

Your Pediatrician (please circle):

Drs. Baumel, Crawford, Garber, Hicks, Rosselot, Whitman

PATIENT:		
Name:	DOB:	☐ Male ☐ Female
Home Address:	City:	Zip Code:
Home Phone:	Patient Cell Phone:	
Social Security #:		
Patient E-Mail Address:		
Is Patient: ☐ American Indian (Native American) ☐ Alaskan Native ☐ Other		

MOTHER/GUARDIAN #1:		
Name:	DOB:	Social Security #:
Employer:	Work Phone:	
Home Address and Phone are the same as Patient? ☐ YES		
Home Address:	City:	Zip Code:
Home Phone:	Cell Phone:	
E-Mail Address:		

FATHER/GUARDIAN #2:		
Name:	DOB:	Social Security #:
Employer:	Work Phone:	
Home Address and Phone are the same as Patient? ☐ YES		
Home Address:	City:	Zip Code:
Home Phone:	Cell Phone:	
E-Mail Address:		

INSURANCE COMPANY:	Subscriber:

EMERGENCY CONTACT other than parent (ex: neighbor, Grandparent):	
Relationship to Patient:	
Home Phone:	Cell Phone:

PREFERRED PHARMACY:
Location of Pharmacy:

ADDITIONAL INFORMATION (if necessary):

PLEASE SEE REVERSE FOR MORE INFORMATION

Framingham Pediatrics, P.C.

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Suite 300
Framingham, Massachusetts 01701
Phone: (508) 879-5764
Fax: (508) 820-0864
www.framinghampediatrics.com

Richard B. Garber, M.D.
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Robin P.B. Hicks, M.D.
James F. Whitman, M.D.
Margaret H. Crawford, M.D.

FINANCIAL POLICY

Our goal is to maintain an excellent physician-patient relationship and for that reason we want you to completely understand our office financial policy. Please read it carefully and do not hesitate to ask a member of our staff if you have any questions.

Prior to your first visit make sure you verify your child's coverage and that you have informed your insurance company of the specific doctor, (PCP) you have chosen. Naming a PCP is a requirement of most insurance companies in order for them to cover your claim. If our doctor does not participate in your plan you will be responsible for the bill.

Review your insurance policy about referrals, authorizations, procedures, and well visit coverage. Vision and hearing screening may not be covered services. Certain immunizations are only covered if they are given at the recommended age so it is important to not postpone these appointments.

At every visit, please check in at the front desk with the most recent insurance card and your contact information. It is imperative that you inform us of any changes in coverage. Co-payments are due at this time as well as any outstanding bills. If you are not covered by insurance, payment is due at the time of visit. For your convenience we accept all major credit cards, checks and cash. You will be billed for any deductibles and coinsurance.

Referrals must be requested 3-5 days prior to the visit. Your child's doctor will have to review and authorize each request. Making sure there is a referral in place for any specialist visit will prevent your being billed for the visit.

Non covered charges you may be responsible for missed appointments, (24 hours notice required), returned checks, medical record transfers, school and camp forms.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. Specifically, I understand and agree that I will be responsible for full payment of any non-covered services, including certain vaccines, provided by the office. I have read all of the information on both sides of this sheet and have completed the required information. I certify this information to be true and accurate to the best of my knowledge. I will notify you of any changes in my health status information I have given.

I hereby give Framingham Pediatrics, P.C. and its physicians my consent for any necessary medical evaluation and treatment.

Patient Name(s)_____

Responsible Party's Name_____ **Relationship** _____

Responsible Party's signature_____ **Date** _____

Patient Name: _____
Today's Date: _____/_____/_____

Medical History Review

Your Pediatrician (please circle): Dr. Baumel, Crawford, Garber, Hicks, Rosselot, Whitman

(please use back of page if you need more space)

PATIENT'S PAST MEDICAL HISTORY (birth, major illnesses, hospitalizations, surgeries)	
DATE:	

PATIENT'S CURRENT MEDICAL PROBLEMS OR NEW CONCERNS

PATIENT'S CURRENT MEDICATIONS (liquid/chewable/pill, dosage and frequency)

PATIENT'S ALLERGIES (MEDICATION, FOOD, OTHER)	
NAME OF MEDICATION/FOOD/OTHER	**TYPE OF REACTION**

FAMILY HISTORY	
Mother's health history:	
Father's health history:	
Sibling (name/age), major medical problems:	
1)	**3)**
2)	**4)**

IS THERE A FAMILY HISTORY OF:	**(please indicate relative and age of onset)**
heart attack, stroke or high cholesterol before age 60?	**Y / N**
sudden or unexplained death?	**Y / N**
chest pain or heart symptoms related to exercise or exertion?	**Y / N**
obesity or weight problems?	**Y / N**
Is there any family history of diabetes?	**Y / N**
other?	