Amherst Pediatrics - New patient intake form

(Office use)

Date received: ______________ Staff initials: _________________

____

Patient/Family Please complete:

Do you think your child(ren) are up to date with their vaccines?

Yes __________ No (but willing to vaccinate) _________ We do not vaccinate ___________

Insurance coverage: ____

Guarantor: ______________________________

DOB: ______________ Relationship: _________________ Member ID#: _______________________

Subscriber name: ____ DOB: ________________

Patient name(s): ____ DOB: __________________

(2) ____ DOB: __________________

(3) ____ DOB: __________________

(4) ____ DOB: __________________

Patient resident address: ____

Mailing address (if different): ____

Legal guardian (1): ____DOB: _________________

Relationship: _____________________________ Email: ______________________________________

Primary ph# ______________________________ Secondary ph# ______________________

Legal guardian (2): ____DOB: _________________

Relationship: _____________________________ Email: ______________________________________

Primary ph# ______________________________ Secondary ph# ______________________

Name of practice transferring from: ____

Phone #: _________________________________ Fax#: _______________________________________

Amherst Pediatrics will contact you to register the patient(s) listed after this form is completed and returned to the office for review

Phone: (413) 253-3773 Fax: (413) 256-0215 Email: mail@amherstpediatrics.net