PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **M** ____

Date of Birth:_____ **Sex:** M / F Gender Identity: _____ **Nickname/goes by** _____

Street Address:_____ **City:**_____ **State:**____ **Zip:**_____

Primary Phone Number:_____ (for voice and text reminders)

Secondary Phone Number:_____ □ Cell □ Landline

Email:_____

Mailing Address (if different):_____

Name(s) of Siblings in This Practice:_____

CMS requires providers to report both race and ethnicity

Circle one-Race: White, Black or African-American, Asian, Japanese, Latino, Multiracial, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, Other, Decline to answer.
Circle One-Ethnicity: Hispanic or Latino, not Hispanic or Latino, Decline to answer.
Circle one-Primary Language: English, French, Portuguese, Hindi, Mandarin, Spanish, Russian, Other.

VFC Status - Choose One:

This child ***is eligible*** for the Federal Vaccines for Children Program (VFC) because he/she:

☐ Is enrolled in Medicaid (We accept MassHealth Partners HealthCare Choice ACO only)
☐ Does not have health insurance (check this box if enrolled in Children's Medical Security Plan)
☐ Is American Indian (Native American) or Alaska Native

This child ***is not eligible*** for the Federal Vaccines for Children Program (VFC) because he/she:

☐ Has health insurance and is not American Indian (Native American) or Alaska Native

HOW DID YOU HEAR ABOUT US?

☐ Another patient in our practice
☐ Website / Social media
☐ OB / GYN
☐ Other: _____

SIGNATURE:_____ **DATE:**_____