RIVERSIDE PEDIATRICS
50 Amaral Street
East Providence, RI 02915

Parents, please fill out this form to update important information for our electronic medical records. Please write clearly, using a BLACK INK PEN as this form will be scanned into patient's medical record.

Primary Doctor (Please Circle one) **Dr. Gabrielsen Dr. Singer**

Patient Information:

Child's Last name: _____First name: _____Middle Initial: _____

Child's Address: _____City:_____State_____Zip_____

Child's D.O.B: ___/____/_____Child's Social Security Number: _____ Circle: Male/Female

Guardian Information:

1st Parent/Guardian: _____Social Security Number: _____D.O.B_____

Address: □ (Please check if address is same as child)

Address: _____City:_____State_____Zip_____

2nd Parent/Guardian: _____Social Security Number: _____D.O.B_____

Address: □ (Please check if address is same as child)

Address: _____City:_____State_____Zip_____

Siblings that are Current Patients at Riverside Pediatrics

1. _____ Date of Birth_____/_____/_____
2. _____ Date of Birth_____/_____/_____
3. _____ Date of Birth_____/_____/_____

Emergency Contact:

Name: _____Phone Number: _____Relationship:_____

Contact Information:

	Check if OK to leave message		Check if OK to leave message
	□ Yes □ No	Patient Cell:_____	□ Yes □ No
Home Phone: _____			
1st Parent Cell:_____	□ Yes □ No	1st Parent Work:_____	□ Yes □ No
2nd Parent Cell _____	□ Yes □ No	2nd Parent Work:_____	□ Yes □ No

Preferred Email: _____

Insurance Information: (MUST BE FILLED OUT COMPLETELY)

Insurance Carrier: _____Policy Number: _____Group Number: _____

Policy Holder's Name: _____Social Security Number: _____ _____ D.O.B__/__/___

Policy Holder's Place of Employment: _____Address:_____

Relationship to Insured: (Please Circle) Child, Step Child, Grandchild, Niece/Nephew, Other: _____

Secondary Insurance (If applicable) _____Policy Number: _____

Policy Holder's Name: _____Social Security Number: _____ _____ D.O.B__/__/___

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Preferred Pharmacy: _____

Address: _____

City: _____ State: _____

Welcome packet given: Date _____ Initial____
Picture taken: Date _____ Initial____

Please Excuse Us…….

The Federal government is now requiring medical practices to collect all sorts of personal information on their patients. This is part of regulations for health care reform, and may be used in reporting data for improvements in public health. If you prefer not to answer the questions, please select "Refuse to Answer".

Would you allow Dr. Gabrielsen, Dr. Singer, and Patricia Lynch- Gadaleta PA to look up your child's medication and health history from external sources? (This will allow us in some cases to select the more appropriate and least costly medication for your child by cross-checking with data from your health insurance company.) **Yes / No**

If Yes, please complete Next Page ...

What type of residence does your child live in?

Residential Home (I.e. Foster Care, Group Home etc...) Private Home (I.e. Apartment, House, Condo etc…) Refuse to Answer

What race do you identify with?

American Indian or Alaskan Asian Native Hawaiian or Other Pacific Island

African American Caucasian Hispanic Other _____ Refuse to Answer

What ethnicity do you identify with?

Hispanic or Latino Not Hispanic or Latino

What if your preferred language when speaking with a provider?

English Spanish Portuguese French Other Refuse to Answer

I hereby authorize the release of any information relating to claims for benefits submitted on behalf of my children, and I authorize Dr. Gabrielsen, Dr. Singer, and Patricia Lynch-Gadaleta, PA to submit claims for benefits for medical services rendered. I consent to allow their access to all other sources of medical records on my child. I give permission for medical information to be left on my personal voicemail, if necessary, when that voicemail is properly identified by name. I have received or been offered a copy of the Notice of Privacy Practices for Dr. Gabrielsen, Dr. Singer, and Patricia Lynch-Gadaleta, PA. If my child will be receiving any immunizations, I am offered a standard vaccine information statement about the reasons and side effects of each vaccine. I understand there is a $25.00 fee for missed appointments not cancelled 24 hours in advance, and a $15 fee for processing bounced checks.

Parent's Signature: _____ Date: _____

Parent's Name Printed: _____