North Reading PEDIATRICS

21 Main Street, Suite 1B,
North Reading, MA 01864
T. 978-664-4698 F. 978-664-1485

Demographic Update

Patients Name:_____D.O.B._____

Please check one box for each question.

Patient's Race: ☐ Asian, ☐ Native Hawaiian or Other Pacific, ☐ Black or African American, ☐ White, ☐ Hispanic, ☐ American Indian or Alaska Native, ☐ Other Race, ☐ Refused to Report

Patient's Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refused to Report

Patient's Preferred Language: _____

Preferred Pharmacy:_____

Preferred Method of Contact: ☐ Patient Portal, Email Address:_____

☐ Home Telephone _____ ☐ Cell_____

Check box if leaving message is permissible ☐ Home ☐ Cell

Due to advance technology we now have the capability, **with your permission**, to enable a search of your current medications with other Providers. (If available)

External Medication Check ☐ Yes ☐ No

*****PATIENTS 18YRS AND OLDER, PLEASE ANSWER THE FOLLOWING QUESTION *****

Do you want any of your medical information shared with anyone other than yourself?
If yes, with whom: **Mother** ☐ **Father** ☐ **Other Adult:_____**

Signature of Parent/Guardian or Patient if 18yrs or older:

_____Date:_____

Rev.1/28/2020