KIDZCARE PEDIATRICS

PATIENT DEMOGRAPHIC FORM

Patient name:____**Email:** ____________________________

Address: ____**Social Security #:** ________________________

City: _________________________________**State:**___________________________ **ZIP:** ___________________

Home Phone: ____________________**Cell Phone:** _________________**Work Phone:** _____________________

Date of Birth: ___________________**Age:** ________________________**Sex:** _____________________________

PARENT INFORMATION: **(List person or Insured name responsible for bill – use legal name)**

Person responsible for bill: ______**Mother** ______**Father** ______**Other Name:** __________________________

Mother's Name: ____**DOB:**___________**SS#**____________________

Mother's Work Phone: ___________________________________**Cell#** _____________________________________

Father's Name: ____**DOB:**___________**SS#** ___________________

Father's Work Phone: ___________________________________**Cell#**_____________________________________

Address (If different from above):

____

Emergency Contact: ______________________________________**Phone #:** _____________________________

INSURANCE INFORMATION: **(PLEASE BRING INSURANCE CARD EACH OFFICE VISIT)**

Primary Insurance: ____

Policy Holder's Name: ____**ID#** ________________________________

Group #: ____________________________**Policy Holder's DOB:** ____

Secondary Insurance: ____

Policy Holder's Name: _______________________________________**ID#**_________________________________

Group #: ____________________________**Policy Holder's DOB:** ____

Pharmacy Name: _______________________________**Pharmacy Location:** _______________________________

_____________ (INITIAL HERE) I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORD OF ANY TREATMENT OR EXAMINATION RENDERED MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO KIDZCARE PEDIATRICS. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MYSELF OR MY DEPENDENT.

SIGNED: ____**DATE:**______________________

Privacy Practice Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it

____**Date:** ______________________________________