

**Kidzcare Pediatrics**  
**119 Epperson Street**  
**Athens, TN 37303**  
**Tel: 423-475-7500 Fax: 423-745-7501**

**Patient Demographics Form**

<b>Patient/Child's Full Name:</b>		
<b>Address:</b>		
<b>City, State and Zip:</b>		
<b>Patient's Social Security Number:</b>	<b>Date of Birth:</b>	<b>Home Phone:</b>
<b>Responsible Party:</b>		<b>Relationship to child:</b>
<b>Responsible Party Address:</b>		<b>Responsible Party Date of Birth:</b> <b>Social Security Number:</b>
<b>Responsible Party Email:</b>		<b>Work Phone:</b>
<b>Contact should reside outside the patient's home.</b> <b>Emergency Contact Name:</b>		<b>Emergency Contact Address:</b>
<b>Relationship to child:</b>		<b>Phone Number:</b>
<b>Primary Insurance:</b>		<b>Secondary Insurance:</b>
<b>Policy Holder Name:</b>		<b>Policy Holder Name:</b>
<b>Date Of Birth:</b>		<b>Date Of Birth:</b>
<b>Policy Holder SS#:</b>		<b>Policy Holder SS#:</b>
<b>Relation to Child:</b>		<b>Relation to Child:</b>
<b>Ok to Leave Message at Home:</b>		<b>Ok to Leave Message at Work:</b>
<b>Pharmacy Name:</b>		<b>Pharmacy Location:</b>

*I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or 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.*  
 \_\_\_\_\_ **Please Initial Here**

Please list below all parties we are authorized to speak with regarding your account and medical information: (EX: Name of Spouse, Name of Mother)

\_\_\_\_\_

**Privacy Practice Acknowledgement**

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

\_\_\_\_\_  
 Patient's Signature (Parent's signature if under 18)

\_\_\_\_\_  
 Date