



For Office Use:

New Patient

Update/Current Patient

Staff Initials: \_\_\_\_\_

## Pediatric Patient Demographics

Please Note: Your insurance card is required at check-in at each visit.

### Patient Information:

Full Name (First, Middle, Last): \_\_\_\_\_ Nickname: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

Email: \_\_\_\_\_ Phone #: \_\_\_\_\_ 2<sup>nd</sup> Phone #: \_\_\_\_\_

Which racial category does the patient most closely identify with? (Check all that apply)

African American  American Indian/Alaska Native  Asian  Caucasian  Hispanic  Native Hawaiian

Other (please specify) \_\_\_\_\_

Ethnicity: What is the patient's ethnicity?

Hispanic/Latino  Not Hispanic/Latino  Other (please specify) \_\_\_\_\_

What is the patient/family's language of preference:  English  Spanish  Other (please specify) \_\_\_\_\_

### Family Information:

Primary Parent/Legal Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Other Parent/Legal Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Primary Insurance Information:

Full Name of Policy Holder: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Employer: \_\_\_\_\_

**Secondary Insurance Information:**

Full Name of Policy Holder: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Employer: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

With whom does the patient reside?  Mother  Father  Both  Other (please specify): \_\_\_\_\_

If all guardians do not reside at the same address as listed above, please provide a secondary address for statements and information. Address: \_\_\_\_\_

**Pharmacy Information:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_