Patient Demographic Form

Patient/Child Information

Child's Name:______________________________ ☐ Male ☐ Female Date of Birth__________________
Child resides with: ☐ Both Parents ☐ Father ☐ Mother ☐ Other

Mother's Name: ______________________________ Date of Birth: __________________
Home Address: ______________________________ City, State, Zip__________________
Home Phone: __________________ Cell Phone:__________________ Work Phone:__________________
Email Address:____

Father's Name:______________________________ Date of Birth: __________________
Home Address:______________________________ City, State, Zip__________________
Home Phone: __________________ Cell Phone:__________________ Work Phone:__________________
Email Address:____

Insurance Information
Primary Insurance: __________________ Member ID: __________________Group #:__________________
Subscriber Name: __________________ Relationship to patient: __________________
Subscriber Employer: ____
Employer Address: __________________ City, State, Zip __________________
Subscriber Social Security: __________________ Subscriber DOB: __________________

Pharmacy Information
Name: __________________
Phone: __________________
Address: __________________
Fax: __________________

Emergency Contact
Name: __________________
Relationship: __________________
Cell phone: __________________
Alt. Phone: __________________

Messages (unless requested otherwise, we only leave our name/phone and general message regarding appointments)
OK to leave a detailed message at home? ☐ YES ☐ NO
OK to leave a detailed message at work? ☐ YES ☐ NO
OK to leave email appointment confirmation? ☐ YES ☐ NO
OK to send statement through Patient Portal? ☐ YES ☐ NO

______________________________ ______________________________
Parent/Guardian Signature Date