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