Primary Care Pediatrics and Family Medicine

Pediatric Demographics

Patient Information:

Name (preferred) _____

Name *(legal):* _____Sex: _____ Date of Birth___/____/___
Last Name First Name Middle Name

Birth Place: _____

Race: ☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ Native American Other _____

School Name: _____ Grade: _____

Home Address: _____City _____State ____ Zip_____

Telephone: Home (___) _____ Cell (___) _____

Marital Status (of parents): ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Widowed

Who does the child live with? _____

Who has legal custody of child? _____

Mother's Name: _____Date of Birth __/__/___ SSN: _____

Telephone: Home (___) _____ Cell (___) _____Email: _____

Occupation: _____ Employer: _____

Father's Name: _____Date of Birth __/__/___ SSN: _____

Telephone: Home (___) _____Cell (___) _____Email: _____

Occupation: _____Employer_____

Under whose policy is the child insured(Guarantor)? _____

Name of Legal Guardian: _____Relationship: _____

Telephone: Home (___) _____ Cell (___) _____Email: _____

Occupation: _____ Employer _____

Primary Care Pediatrics and Family Medicine P.C. may contact me via: ☐ Phone ☐ Portal

Please list phone numbers and relationship with children in order you prefer us call you.

Phone Number	Relationship							
#1. _____	Father:	☐ Cell	☐ Home	Mother:	☐ Cell	☐ Home
#2. _____	Father:	☐ Cell	☐ Home	Mother:	☐ Cell	☐ Home
#3. _____	Father:	☐ Cell	☐ Home	Mother:	☐ Cell	☐ Home
#4. _____	Father:	☐ Cell	☐ Home	Mother:	☐ Cell	☐ Home

Primary Care Pediatrics and Family Medicine, P.C may leave messages or lab results via

☐ Phone: Father ☐ Home ☐ Cell Mother ☐ Home ☐ Cell

☐ Portal

☐ Primary Care Pediatrics and Family Medicine, P.C., may not leave message or lab result.

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Primary Care Pediatrics and Family Medicine may send me appointment reminder via
☐ Email: _____
☐ Text: _____

Emergency Contact other than parents
Name_____ ☐Phone_____ Relationship_____
Name: _____ Phone _____ Relationship_____

PREFERRED PHARMACY (name, location, phone number)
_____

Child's Previous Pediatrician: _____ Tel: (___) _____
Reason for leaving_____
How did you hear about us? ☐Website ☐Google search ☐Medical Insurance ☐Facebook
☐Friends/ Family ☐Others_____

INSURANCE INFORMATION:
Primary Insurance Co_____ Insured's Name _____DOB_____
Group No._____ Contract No._____
Secondary Insurance Co _____Insured's Name_____ DOB_____
Group No._____ Contract No._____

I hereby authorize and direct payment to Primary Care Pediatrics and Family Medicine P.C, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize Primary Care Pediatrics and Family Medicine, P.C. to release any information acquired in the course of my treatment necessary to my insurance company for the purpose of processing insurance claims. I understand that regardless of my insurance status, I am solely responsible for payment of any services rendered to me, or on my behalf, whether or not paid by my insurance.

Patient / responsible party's signature Date
_____ _____
Name:
_____