Primary Care Pediatrics
and Family Medicine
29869 Capshaw Road, Harvest, AL 35749
Phone:256-262-1040

Pediatric Demographics

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.

Primary Care Pediatrics and Family Medicine
29869 Capshaw Road, Harvest, AL 35749
Phone:256-262-1040

Pediatric Demographics

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 noncovered 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.
In the event of non-payment or default, I am responsible for all costs of collections, including, but not limited to, collection agency fees, court costs, and reasonable attorney fees.

_____ _____ _____
Signature of Patient/Responsible Party Name of Responsible Party Date