TODAY'S DATE: ________________

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION:

Child's Name:________________________ DOB:____________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):________________

Child's Name:________________________ DOB:____________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):________________

Child's Name:________________________ DOB:____________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):________________

Child's Name:________________________ DOB:____________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):________________

PARENT / LEGAL GUARDIAN #1 - *LIVING IN SAME HOUSEHOLD AS PATIENTS & PRIMARY CONTACT FOR APPOINTMENT REMINDERS

Name: ________________________________ DOB: ____________ Relationship to Patient:______________________

Address: ____ City / State / Zip: __________________________________

Primary Phone #:____________________ ☐ Cell ☐ Home ☐ Other________ Alternate Phone #:__________________ ☐ Cell ☐ Home ☐ Other ________

Occupation: _____________________________________ Employer: _______________________________________

Email: ____ ❑ I agree to receive email & text notifications from Elmwood Pediatrics

PARENT / LEGAL GUARDIAN #2

Name: ________________________________ DOB: ____________ Relationship to Patient:______________________

Address: ____ City / State / Zip: __________________________________

Primary Phone #:____________________ ☐ Cell ☐ Home ☐ Other________ Alternate Phone #:__________________ ☐ Cell ☐ Home ☐ Other ________

Occupation: _____________________________________ Employer: _______________________________________

Email: ____ ❑ I agree to receive email & text notifications from Elmwood Pediatrics

PARENTS / LEGAL GUARDIANS (please circle) : **Married Living Together Single Widowed Separated Divorced**

If Divorced or Separated, who is the Custodial Parent? ______________________________________

**PLEASE NOTE*: LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS.*

PRIMARY INSURANCE: **Billing Address & Responsible Party for Billing Issues**: ❑ **Parent/Guardian #1** ❑ **Parent/Guardian #2**

Plan Name: _______________________________ ID #: __________________________ Effective Date:_____________

Subscriber: __________________________ Subscriber DOB: ___________ Relationship to Patient: ________________

SECONDARY INSURANCE INFORMATION (if applicable):

Plan Name: _______________________________ ID #: __________________________ Effective Date:_____________

Subscriber: __________________________ Subscriber DOB: ___________ Relationship to Patient: ________________

The Elmwood Pediatric Group will submit medical claims to the insurance company based on information I have provided. I understand that I am responsible for updating insurance information each time services are rendered. If this insurance information is not correct, I understand that I will be responsible for any charges. I further understand that Elmwood Pediatric Group has privacy policies and financial policies in place. I have been offered the opportunity to read and receive a copy of Elmwood Pediatric Groups' Notice of Privacy Practices and Financial Policy.

Parent/Legal Guardian Signature:___________________________ **Relationship to Patient**:______________________ Date:_________

For Office Use Only: ❑ Scanned ❑ Account Updated & Scanned (initials):_______ Date:_________ / ❑ Scanned & Given to Billing initials):_______ Date:_________