PATIENT DEMOGRAPHIC SHEET

md/15 PF002 Patient Demo.doc

PLEASE PRINT (List all children separately, Circle parent that each child lives with, turn over for additional information)

Child (1) Full Name__________________________________DOB____________Gender_____SS#____________________

Primary Insurance________________________________ID#____________________Grp#______________Copay $______

Subscriber Name___________________________DOB__________Relationship to Patient_____________SS#____________

Secondary Insurance_______________________________ID#____________________Grp#______________Copay $______

Subscriber Name___________________________DOB__________Relationship to Patient_____________SS#____________

Mother/Father Full Name________________________________DOB__________SS#_______________Marital Status_____

Address____City/State/Zip____

Hm Phone #________________________Wk Phone #_________________________Cell Phone #________________________

Employer Name/Address____

Father/Mother Full Name_________________________________DOB__________SS#_____________Marital Status_______

Address____City/State/Zip____

Hm Phone #________________________Wk Phone #_________________________Cell Phone #________________________

Employer Name/Address____

Child is eligible for immunizations through the federal VFC Program because he/she is:
□ American Indian (Native American) or □ Alaska Native

American) or

Child is *not* VFC eligible because he/she has:
□ health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native

Alaska Native

Ethnicity: □ Hispanic □ Non-Hispanic □ Refuse to Report **Race:** ________________________

Child (2) Full Name__________________________________DOB____________Gender_____SS#____________________

Primary Insurance________________________________ID#____________________Grp#______________Copay $______

Subscriber Name___________________________DOB__________Relationship to Patient_____________SS#____________

Secondary Insurance______________________________ID#____________________Grp#______________Copay $_______

Subscriber Name___________________________DOB__________Relationship to Patient_____________SS#____________

Mother/Father Full Name______________________________ DOB__________SS#_______________Marital Status_______

Address____City/State/Zip____

Hm Phone #________________________Wk Phone #_________________________Cell Phone #________________________

Employer Name/Address____

Father/Mother Full Name_________________________________DOB__________SS#_____________Marital Status_______

Address____City/State/Zip____

Hm Phone #________________________Wk Phone #_________________________Cell Phone #________________________

Child is eligible for immunizations through the federal VFC Program because he/she is:
□ American Indian (Native American) or □ Alaska Native

American) or

Child is *not* VFC eligible because he/she has:
□ health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native

Alaska Native

Ethnicity: □ Hispanic □ Non-Hispanic □ Refuse to Report **Race:** ________________________

Child (3) Full Name________________________________DOB____________Gender_____SS#____________________

Primary Insurance______________________________ID#___________________Grp#______________Copay $______

Subscriber Name_________________________DOB__________Relationship to Patient_____________SS#____________

Secondary Insurance______________________________ID#___________________Grp#______________Copay $______

Subscriber Name_________________________DOB__________Relationship to Patient_____________SS#____________

Mother/Father Full Name_____________________________ DOB__________SS#______________Marital Status_______

Address_______________________________________City/State/Zip____

Hm Phone #_______________________Wk Phone #________________________Cell Phone #______________________

Father/Mother Full Name________________________________DOB__________SS#_____________Marital Status_______

Address_______________________________________City/State/Zip____

Hm Phone #_______________________Wk Phone #________________________Cell Phone #______________________

Child is eligible for immunizations through the federal VFC Program because he/she is:
□ American Indian (Native American) or □ Alaska Native

Child is *not* VFC eligible because he/she has:
□ health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native American) or Alaska Native

Ethnicity: □ **Hispanic** □ **Non-Hispanic** □ **Refuse to Report** **Race:** ________________________

Child (4) Full Name________________________________DOB____________Gender_____SS#____________________

Primary Insurance______________________________ID#___________________Grp#______________Copay $______

Subscriber Name_________________________DOB__________Relationship to Patient_____________SS#____________

Secondary Insurance______________________________ID#___________________Grp#______________Copay $______

Subscriber Name_________________________DOB__________Relationship to Patient_____________SS#____________

Mother/Father Full Name_____________________________ DOB__________SS#______________Marital Status_______

Address_______________________________________City/State/Zip____

Hm Phone #_______________________Wk Phone #________________________Cell Phone #______________________

Father/Mother Full Name________________________________DOB__________SS#_____________Marital Status_______

Address_______________________________________City/State/Zip____

Hm Phone #_______________________Wk Phone #________________________Cell Phone #______________________

Child is eligible for immunizations through the federal VFC Program because he/she is:
□ American Indian (Native American) or □ Alaska Native

Child is *not* VFC eligible because he/she has:
□ health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native American) or Alaska Native

Ethnicity: □ **Hispanic** □ **Non-Hispanic** □ **Refuse to Report** **Race:** ________________________

I authorize the release of my child's/children's medical information necessary to process this claim.

I authorize the release of payment of medical benefits to my child's/children's physician.

I understand that I am financially responsible for payment of service not covered by my insurance company.

I have received a copy of Pediatric Associate's HIPAA privacy act.

Parent/Guardian Signature____**Date:**________________