Healthy Kids Pediatrics
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

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Healthy Kids Pediatrics; I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

By signing below, I certify that I have read and understand the HIPAA Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____
Parent/Guardian Signature Date