Creekview Pediatrics

caring for your child from birth to 21 yrs

Patient Demographic Form

Please list **ALL** of your children on this form: Please Print Clearly

Name: ______________________________ **DOB:**__________ ☐ Male ☐ Female

Please check one for each question: **Ethnicity:** ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Name: ______________________________ **DOB:**__________ ☐ Male ☐ Female

Please check one for each question: **Ethnicity:** ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Name: ______________________________ **DOB:**__________ ☐ Male ☐ Female

Please check one for each question: **Ethnicity:** ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Name: ______________________________ **DOB:**__________ ☐ Male ☐ Female

Please check one for each question: **Ethnicity:** ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Unknown ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Address: ______________________________City:____________ State:____ Zip:______

With whom does the child reside? ______________________________

Preferred Contact Phone #: ____________________ Preferred Language: ______________

*Phone # to leave confidential information (eg lab results) on voicemail:*____________________

Mother: __________________ DOB:______ Father: __________________ DOB:______

Email: __________________________ Email: __________________________

Cell Phone #: ____________________ Cell Phone #:____________________

Employer: ______________________ Employer: ______________________

Work #: ________________________ Work #: ________________________

To whom may we send a Thank You for referring you to our office?

☐ Friend ____________ ☐ Doctor ____________ ☐ Insurance ☐ Other ____________

Emergency Contact:__________________ Relation:__________ Phone #: ______________

I, the undersigned, have insurance as stated below and assign directly to the physicians at Creekview Pediatrics all surgical and/or medical benefits, if any, payable to me for services. I hereby give permission to physicians at Creekview Pediatrics and the staff to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

Payment is expected at the time of services. Please feel free to discuss any financial concerns you have.

Primary insurance: ______________ Policy#:__________________ Group#: __________

Subscriber:________________________DOB:________ Relationship to patient: __________

Secondary insurance: ______________ Policy#:__________________ Group#: __________

Subscriber:________________________DOB:________ Relationship to patient: __________

Signed By: ________________________________ Date: ____________________

Signature of patient or parent/guardian if patient is under 18 years of age