



PATIENT DEMOGRAPHIC INFORMATION – PEDIATRIC

Today's Date: ____/____/____

Referred by *(If Applicable)*: _____

CHILD INFORMATION

OFFICE USE (P#):

LAST NAME:		FIRST NAME:		MIDDLE NAME:	
DATE OF BIRTH (<i>mm/dd/yyyy</i>):		E-MAIL ADDRESS (For Patient Communications):			
		USE THIS EMAIL FOR PATIENT PORTAL ACCOUNT: <input type="checkbox"/> Yes <input type="checkbox"/> No			
MAILING ADDRESS:		CITY:	STATE:	ZIP:	
PHYSICAL ADDRESS (<i>If different from mailing address</i>):		CITY:	STATE:	ZIP:	
Preferred Name:	SEX ASSIGNED AT BIRTH: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	RACE: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Alaskan Native/American Indian <input type="checkbox"/> Refuse to Report <input type="checkbox"/> Other:			
GENDER IDENTITY: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Man <input type="checkbox"/> Transgender Woman <input type="checkbox"/> Non-binary <input type="checkbox"/> Unknown		GENDER PRONOUNS: <input type="checkbox"/> she/her/hers <input type="checkbox"/> he/him/his <input type="checkbox"/> they/them/their <input type="checkbox"/> Other:			
ETHNICITY: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refuse to Report		PREFERRED LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify): _____ Translator Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No			

PARENT/LEGAL GUARDIAN #1 - GUARANTOR (Individual responsible for bills and payment)

OFFICE USE (Account #):

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:	
RELATIONSHIP TO CHILD (<i>Check ONE</i>): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (<i>Please specify</i>):			GENDER IDENTITY: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Man <input type="checkbox"/> Transgender Woman <input type="checkbox"/> Non-binary <input type="checkbox"/> Unknown		
STREET ADDRESS: <input type="checkbox"/> <i>Check if same as patient</i>		CITY:	STATE:	ZIP	
HOME PHONE: ()	CELL PHONE: ()	WORK PHONE: ()		EXTENSION:	
E-MAIL ADDRESS: <input type="checkbox"/> None <input type="checkbox"/> Prefer Not To Disclose		SOCIAL SECURITY #:		DATE OF BIRTH (<i>mm/dd/yyyy</i>):	
EMPLOYER NAME:				EMPLOYER PHONE #: ()	

PARENT/LEGAL GUARDIAN #2

LAST NAME:		FIRST NAME:			
RELATIONSHIP TO CHILD (<i>Check ONE</i>): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other (<i>Please specify</i>):			GENDER IDENTITY: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Man <input type="checkbox"/> Transgender Woman <input type="checkbox"/> Non-binary <input type="checkbox"/> Unknown		
STREET ADDRESS: <input type="checkbox"/> <i>Check if same as patient</i>		CITY:	STATE:	ZIP:	
HOME PHONE: ()	CELL PHONE: ()	WORK PHONE: ()			

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

