

RICHMOND PEDIATRICS
PATIENT DEMOGRAPHIC FORM
Please Print

Date:

PATIENT INFORMATION				
Last Name		First Name		Middle Initial
Date of Birth		Social Security Number		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race <input type="checkbox"/> Black-Non-Hispanic <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White-Non-Hispanic <input type="checkbox"/> Other				
Home Address		Apt#	City	State
Home Phone		Work Phone	Other Phone <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax	
Email Address		Preferred Phone No.		Language Other than English

RESPONSIBLE PARTIES			
Patient Lives With: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (Name-Relationship):			
Father's Name: Last:		First:	Middle Initial:
		DOB:	
Address/Phone Same as Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No: Address:		City:	State
		Zip Code	
Home Phone:		Cell Phone:	SSN:
Employer:		Occupation:	Emp Phone #:
Mother's Name: Last:		First:	Middle Initial:
		DOB:	
Address/Phone Same as Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If No: Address:		City:	State
		Zip Code	
Home Phone:		Cell Phone:	SSN:
Employer:		Occupation:	Emp Phone #:

Person Responsible for Insurance: Father Mother Other (Name-Relationship):

PATIENT'S INSURANCE INFORMATION** Please provide Insurance Card and Pharmacy Card to our Receptionist

PRIMARY INSURANCE		
Is patient a full time student in secondary education on parent's insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Insurance Company		ID/Member #:
		Group #:
Policy Holder's Name:		Policy Holder's DOB:
		Member/Customer Service Phone #:

SECONDARY INSURANCE		
Is secondary insurance available: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Insurance Company		ID/Member #:
		Group #:
Policy Holder's Name:		Policy Holder's DOB:
		Member/Customer Service Phone #:

PHARMACY CHOICE			
Name:		City:	Zip Code:
Address:		State:	Phone No.:

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nickname/AKA
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EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name:	First Name:	Relationship to Patient		
Address:	Apt#	City	State	Zip Code
Home Phone:	Cell Phone:	Work Phone:		

SIBLING INFORMATION

Name:	Date of Birth:	Name:	Date of Birth:
Name:	Date of Birth:	Name:	Date of Birth:
Name:	Date of Birth:	Name:	Date of Birth:

OTHER CONTACT INFORMATION - NOT LIVING WITH PATIENT

Last Name:	First Name:	Relationship to Patient		
Address:	Apt#	City	State	Zip Code
Home Phone:	Cell Phone:	Work Phone:		

Charges for new patients are due and payable at the time of the first visit unless a valid insurance card is presented.

I authorize my insurance benefits to be paid directly to Richmond Pediatrics. I hereby authorize the physician or insurance company to release my information necessary to secure payment.

Signature: _____

Date: _____