Pediatric Associates of Brockton

TODAY'S DATE: ___________________

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION:

Patient's Name:_________________________ DOB:_____________ ❑ Male / ❑ Female / Other ______________________________

Patient/Family Language of Preference:___________________________ ❑ Patient Cell # (13+yr):_________________________________

What is the patient ethnicity? Hispanic / Non-Hispanic / Refuse to Report ❑ Patient Email (13+yr):_________________________________

Which racial category does the patient most closely identify with?___________________________________

African American, American Indian / Alaska Native, Caucasian, Hispanic, Native Hawaiian/Other Pacific Islander, More than One Race, Other

PARENT / LEGAL GUARDIAN #1 - ***LIVING IN SAME HOUSEHOLD AS PATIENTS & PRIMARY CONTACT FOR APPOINTMENT REMINDERS**

Name: ____________________________________ DOB: _______________ Relationship to Patient:________________________

Address: ____ City / State / Zip: ______________________________________

Primary Phone #:_______________________ ☐ Cell ☐ Home ☐ Other_________ Alternate Phone #:______________________ ☐ Cell ☐ Home ☐ Other _________

Occupation: ____ Employer: ____

Email: ____ ❑ I agree to receive email & text notifications from Pediatric Associates of Brockton

PARENT / LEGAL GUARDIAN #2

Name: ____________________________________ DOB: _______________ Relationship to Patient:________________________

Address: ____ City / State / Zip: ______________________________________t

Primary Phone #:_______________________ ☐ Cell ☐ Home ☐ Other_________ Alternate Phone #:______________________ ☐ Cell ☐ Home ☐ Other _________

Occupation: ____ Employer: ____

Email: ____ ❑ I agree to receive email & text notifications from Pediatric Associates of Brockton

PARENTS / LEGAL GUARDIANS (please circle) : **Married** **Living Together** **Single** **Widowed** **Separated** **Divorced**

If Divorced or Separated, who is the Custodial Parent? ____

**PLEASE NOTE*: LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS.*

PRIMARY INSURANCE:

Billing Address & Responsible Party for Billing Issues: ❑ **Parent/Guardian #1** ❑ **Parent/Guardian #2**

Plan Name: ___________________________________ ID #: ____________________________ Effective Date:_______________

Subscriber: _____________________________ Subscriber DOB: ____________ Relationship to Patient: __________________

SECONDARY INSURANCE INFORMATION (if applicable):

Plan Name: _________________________________ ID #: ____________________________ Effective Date:______________

Subscriber: ____________________________ Subscriber DOB: ____________ Relationship to Patient: _________________

Pediatric Associates of Brockton will submit medical claims to the insurance company based on my provided information I have provided. I understand that I am responsible for updating insurance information each time services are rendered. If this insurance information is not correct, I understand that I will be responsible for any charges. I further understand that Pediatric Associates of Brockton has privacy policies and financial policies in place. I have been offered the opportunity to read and receive a copy of Pediatric Associates of Brockton's Notice of Privacy Practices and Financial Policy.

Parent/Legal Guardian Signature:_____________________________ **Relationship to Patient**:_______________________ Date:__________

Please list other children's names and dates of birth on the reverse side of this paper.

For Office Use Only: ❑ Scanned ❑ Account Updated & Scanned (initials):________ Date:__________ / ❑ Scanned & Given to Billing initials):________ Date:__________

PATIENT DEMOGRAPHIC FORM CONTINUED

PATIENT INFORMATION:

Child's Name:______________________________ DOB:________________ ❑ Male / ❑ Female / Other ________________________________

Child's Name:______________________________ DOB:________________ ❑ Male / ❑ Female / Other ________________________________

Child's Name:______________________________ DOB:________________ ❑ Male / ❑ Female / Other ________________________________

Child's Name:______________________________ DOB:________________ ❑ Male / ❑ Female / Other ________________________________

Child's Name:______________________________ DOB:________________ ❑ Male / ❑ Female / Other ________________________________

Child's Name:______________________________ DOB:________________ ❑ Male / ❑ Female / Other ________________________________