



New Patient Demographic Form

Primary Doctor: \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Gender** (Please Mark One): \_\_\_M \_\_\_F  
 (First) (Middle) (Last)

**Date of Birth:** \_\_\_\_\_ **Place of Birth:** \_\_\_\_\_  
 (mm / dd / yyyy) (City and State)

**Home Address:** \_\_\_\_\_  
 (Street) (City) (State) (Zip)

*If you experience a move throughout our care for your child please update this information with your home office.*

**Mother/Guardian's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Alternate #:** \_\_\_\_\_  
**Primary Phone Number** (Please Mark One): Home #  Cell #  Alternate #

Email Address: \_\_\_\_\_

**Father/Guardian's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Alternate #:** \_\_\_\_\_  
**Primary Phone Number** (Please Mark One): Home #  Cell #  Alternate #

Email Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Sibling's Names and Dates of Birth:

1.) \_\_\_\_\_ DOB: \_\_\_\_\_ 4.) \_\_\_\_\_ DOB: \_\_\_\_\_

2.) \_\_\_\_\_ DOB: \_\_\_\_\_ 5.) \_\_\_\_\_ DOB: \_\_\_\_\_

3.) \_\_\_\_\_ DOB: \_\_\_\_\_ 6.) \_\_\_\_\_ DOB: \_\_\_\_\_

**Family History:** (Please Circle Y or N and explain if indicated)

**Allergies/Asthma** Y / N If Yes, Please Explain \_\_\_\_\_

**Diabetes** Y / N If Yes, Please Explain \_\_\_\_\_

**Hypertension** Y / N If Yes, Please Explain \_\_\_\_\_

**Convulsive Disorders** Y / N If Yes, Please Explain \_\_\_\_\_

**Sickle Cell** Y / N If Yes, Please Explain \_\_\_\_\_

**Cardiovascular Disease** Y / N If Yes, Please Explain \_\_\_\_\_



**Child's Birth and Development History:**

Born at (Name of Hospital): \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Any Problems with pregnancy or delivery: \_\_\_\_\_

Full Term Birth? Y / N If No, How Many weeks at birth? \_\_\_\_\_

Type of Delivery (Please Select One):  Vaginal  C-Section

NICU (Please Select One): Y / N If Yes, Reason for NICU Hospitalization? \_\_\_\_\_

Hepatitis B Vaccine Date (if Newborn): \_\_\_\_\_

Any Chronic Illnesses: \_\_\_\_\_

Any Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies (medicines, food, environmental): \_\_\_\_\_

School: \_\_\_\_\_ Grade in School: \_\_\_\_\_

**Demographic Information**

The Federal Government requires all medical practices to collect the following information from patients.

There is a provision in the law that allows patients to not answer these questions.

Please answer the following three questions or select the "I decline to provide this information" answer.

**1.) My Child's Ethnicity is:** (Please Select One)

- A. Hispanic or Latino
- B. Not Hispanic or Latino

**2.) My Child's Race is:** (Please Select One)

- A. American Indian/Alaskan Native
- B. Asian
- C. Black or African American
- D. Native Hawaiian or Pacific Islander
- E. White/Caucasian
- F. Other

**3.) My Child's Preferred Language is:** (Please Select One)

- A. English
- B. Spanish
- C. Other: \_\_\_\_\_

(Please Provide Preferred Language)

I decline to provide this information

**Emergency Contact**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Name of person filling out this form (printed): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_