

PENINSULA CHILDREN'S CLINIC PATIENT DEMOGRAPHIC

Please fill out completely. If something does not apply please put N/A. It is important that we have all the current accurate information so we are able to reach your family regarding your child's health.

Date _____

PATIENT'S NAME _____
(Legal Name) Last First M.I.

Goes by: _____

PATIENT'S _____
Date of Birth Sex Practitioner at Delivery

PARENT'S NAMES _____
Father's First & Last Name Mother's First & Last Name

- Married
- Single
- Divorced

STEP PARENTS _____
Step father's Name Step Mother's Name

OR GUARDIAN _____

CHILD LIVES WITH (Circle all that apply) **Mother** **Father** **Grandparents**
Guardian **Stepparent**

Childs Home Address _____
Street City State Zip

Childs Mailing Address (If different from Home Address) _____
Street City State Zip

Non Cust. Parent Address _____
Street City State Zip

P H O N E S

Father:	_____	_____	_____
	Home Phone	Work Phone	Cell Phone
Mother:	_____	_____	_____
	Home Phone	Work Phone	Cell Phone
Guardian:	_____	_____	_____
	Home Phone	Work Phone	Cell Phone

Message Phone # _____ **Name:** _____

Employer: _____
Father Mother

Insurance: Primary _____ **CO-PAY AMT.** _____

Policy Holder's Name _____ ID# _____

Secondary _____

Policy Holder's Name _____ ID# _____

Social Security Numbers:

_____ Father's Mother's Patient's Guardian