COPC - STEP BY STEP PEDIATRICS
540 N Cleveland Ave Suite 200
Westerville, Ohio, 43082
614-891-9505
614-891-6416

CENTRAL OHIO PRIMARY CARE

PLEASE CIRCLE ONE:
Dr. Alana Milton
Dr. Cameron Miller
Dr. William Knobeloch
Dr. Mary-Lynn Niland
Dr. Katrina Tansky
Dr. Nicole Van Steyn

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 *(mm/dd/yyyy)*:	E-MAIL ADDRESS (For Patient Communications): USE THIS EMAIL FOR PATIENT PORTAL ACCOUNT: □ Yes □ No	

MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS *(If different from mailing address)*:	CITY:	STATE:	ZIP:

Preferred Name:	SEX ASSGNED AT BIRTH: □ Male □ Female □ Unknown	RACE: □ White □ Asian □ Black/African American □ Native Hawaiian/Other Pacific Islander □ Alaskan Native/American Indian □ Refuse to Report □ Other:

GENDER IDENTITY: □ Male □ Female □ Transgender Man □ Transgender Woman □ Non-binary □ Unknown	GENDER PRONOUNS: □ she/her/hers □ he/him/his □ they/them/their □ Other:

ETHNICITY: □ Hispanic/Latino □ Non-Hispanic/Latino □ Refuse to Report	PREFERRED LANGUAGE: □ English □ Spanish □ Other (please specify):_____ Translator Needed: □ Yes □ No

PARENT/LEGAL GUARDIAN #1 - GUARANTOR

(Individual responsible for bills and payment) OFFICE USE (Account #):

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
RELATIONSHIP TO CHILD *(Check ONE)*: □ Mother □ Father □ Legal Guardian □ Stepmother □ Stepfather □ Other *(Please specify)*:	GENDER IDENTITY: □ Male □ Female □ Transgender Man □ Transgender Woman □ Non-binary □ Unknown	

STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP

HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	EXTENSION:

E-MAIL ADDRESS: □ None □ Prefer Not To Disclose	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:
EMPLOYER NAME:		EMPLOYER PHONE #: ( )

PARENT/LEGAL GUARDIAN #2

LAST NAME:	FIRST NAME:	
RELATIONSHIP TO CHILD *(Check ONE)*: □ Mother □ Father □ Legal Guardian □ Stepmother □ Stepfather □ Other *(Please specify)*:	GENDER IDENTITY: □ Male □ Female □ Transgender Man □ Transgender Woman □ Non-binary □ Unknown	

STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP:

HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

EMERGENCY CONTACT (Individual must be over the age of 18)

LAST NAME:	FIRST NAME:	RELATIONSHIP TO CHILD *(Please specify)*:
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

ADDITIONAL CONTACT (OPTIONAL) (Individual must be over the age of 18)

LAST NAME:	FIRST NAME:	RELATIONSHIP TO CHILD *(Please specify*
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

PATIENT IS INSURED: □ Yes □ No *(Self Pay)*			
NAME OF PRIMARY INSURANCE:		NAME OF SECONDARY INSURANCE:	
SUBSCRIBER'S NAME:		SUBSCRIBER'S NAME:	
RELATIONSHIP TO CHILD: □ Mother □ Father □ Stepmother □ Stepfather □ Other *(Please specify):*		RELATIONSHIP TO CHILD: □ Mother □ Father □ Stepmother □ Stepfather □ Other *(Please specify):*	
SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with the subscriber's insurance company? □ Male □ Female		SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with the subscriber's insurance company? □ Male □ Female	
DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:

HOW DID YOU HEAR ABOUT US?

□ Community Event □ COPC Website □ Facebook □ Health Plan Website □ Internet Search □ Online Reviews
□ Outdoor/ Billboard Advertisement □ Print Advertisement □ Radio Advertisement □ Television Advertisement
□ Referred by COPC Physician □ Referred from Friend/Family □ Other_____

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from COPC in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding patient's protected health information as follows:	POSTAL COMMUNICATIONS –Please mail patient's protected health information as follows:
Check ALL that Apply □ Home Phone of Record □ Brief □ Extended □ Cell Phone of Record □ Brief □ Extended □ Work Phone of Record □ Brief □ Extended *Example of Brief: Time/Day of Appointment* *Example of Extended: Lab Results*	Select Only One: □ Mailing Address of Record □ Physical Address of Record □ Other: _____ Street Address _____ City State Zip

ACKNOWLEDGEMENT

By signing below, I acknowledge that I am the parent and/or legal guardian of this child. If a non-parental legal guardian, I have already provided supporting legal documents outlining my custodial rights to the office.

Print Name	Signature	Date