# 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):**<br>**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:**<br>□ Male<br>□ Female<br>□ Unknown | **RACE:** □ White □ Asian □ Black/African American<br>□ Native Hawaiian/Other Pacific Islander<br>□ Alaskan Native/American Indian<br>□ Refuse to Report<br>□ Other: | |
| **GENDER IDENTITY:** □ Male □ Female<br>□ Transgender Man □ Transgender Woman<br>□ Non-binary □ Unknown | **GENDER PRONOUNS:** □ she/her/hers □ he/him/his<br>□ they/them/their<br>□ Other: | | |
| **ETHNICITY:** □ Hispanic/Latino<br>□ Non-Hispanic/Latino<br>□ Refuse to Report | **PREFERRED LANGUAGE:** □ English □ Spanish<br>□ Other (please specify):__________________<br>**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*):**<br>□ Mother □ Father □ Legal Guardian □ Stepmother □ Stepfather<br>□ Other (*Please specify*): | **GENDER IDENTITY:**<br>□ Male □ Female □ Transgender Man □ Transgender Woman<br>□ Non-binary □ Unknown | | |
| **STREET ADDRESS:** □ ***Check if same as patient*** | **CITY:** | **STATE:** | **ZIP** |
| **HOME PHONE:**<br>( ) | **CELL PHONE:**<br>( ) | **WORK PHONE:**<br>( ) | **EXTENSION:** |
| **E-MAIL ADDRESS:**<br>□ 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*):**<br>□ Mother □ Father □ Legal Guardian □ Stepmother □ Stepfather<br>□ Other (*Please specify*): | **GENDER IDENTITY:**<br>□ Male □ Female □ Transgender Man □ Transgender Woman<br>□ Non-binary □ Unknown | | |
| **STREET ADDRESS:** □ ***Check if same as patient*** | **CITY:** | **STATE:** | **ZIP:** |
| **HOME PHONE:**<br>( ) | **CELL PHONE:**<br>( ) | **WORK PHONE:**<br>( ) | |

***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<br>□ Home Phone of Record □ Brief □ Extended<br>□ Cell Phone of Record □ Brief □ Extended<br>□ Work Phone of Record □ Brief □ Extended<br><br>*Example of Brief: Time/Day of Appointment*<br>*Example of Extended: Lab Results* | Select Only One:<br>□ Mailing Address of Record □ Physical Address of Record<br>□ Other:<br>_______________________________________________<br>Street Address<br>_______________________________________________<br>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

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