Family Demographic Form (please fill out each section completely)

Computer numbers (office use only) _____ Today's Date: _____

Family last name(s) _____ All children's first names (our patients) _____

Who does patients live with? MOM/DAD/BOTH/OTHER: _____

Parent/Guardian

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ (home or cell?) Primary/Secondary? Email address: _____

Parent/Guardian Address same as above? ☐

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ (home or cell?) Primary/Secondary? Email address: _____

Insurance Information

Person responsible for insurance

Last Name: _____ First Name: _____ Date of Birth: _____

Address same as above? ☐

Address: _____ City: _____ State: _____ Zip code: _____

Phone: _____ (home or cell?) Alt phone: _____ (home or cell?)

Relationship to patient: _____

Primary Insurance:

Insurance Name: _____ Enrollee name: _____ Date of birth: _____

Relationship to patient: _____

Secondary Insurance: (if applicable)

Insurance Name: _____ Enrollee name: _____ Date of birth: _____

Relationship to patient: _____

_____

Signature of parent/guardian filling out form **Printed name** **Date**