



PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION:

Patient's Name: _____ DOB: _____ ☐ Male / ☐ Female / Other _____

Patient/Family Language of Preference: _____ ☐ Patient Cell # (13+yr): _____

What is the patient ethnicity? ☐ Hispanic / ☐ Non-Hispanic / ☐ Refuse to Report ☐ Patient Email (13+yr): _____

Which racial category does the patient most closely identify with? _____
African American, American Indian / Alaska Native, Caucasian, Hispanic, Native Hawaiian/Other Pacific Islander, More than One Race, Other

PARENT / LEGAL GUARDIAN #1 - *LIVING IN SAME HOUSEHOLD AS PATIENTS & PRIMARY CONTACT FOR APPOINTMENT REMINDERS

Name: _____ DOB: _____ Relationship to Patient: _____

Address: _____ City / State / Zip: _____

Primary Phone #: _____ ☐ Cell ☐ Home ☐ Other _____ Alternate Phone #: _____ ☐ Cell ☐ Home ☐ Other _____

Occupation: _____ Employer: _____

Email: _____ ☐ I agree to receive email & text notifications from Pediatric Associates of Brockton

PARENT / LEGAL GUARDIAN #2

Name: _____ DOB: _____ Relationship to Patient: _____

Address: _____ City / State / Zip: _____

Primary Phone #: _____ ☐ Cell ☐ Home ☐ Other _____ Alternate Phone #: _____ ☐ Cell ☐ Home ☐ Other _____

Occupation: _____ Employer: _____

Email: _____ ☐ I agree to receive email & text notifications from Pediatric Associates of Brockton

PARENTS / LEGAL GUARDIANS (please circle) ☐ Married ☐ Living Together ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

If Divorced or Separated, who is the Custodial Parent? _____

PLEASE NOTE: LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS.

PRIMARY INSURANCE: Billing Address & Responsible Party for Billing Issues: ☐ Parent/Guardian #1 ☐ Parent/Guardian #2

Plan Name: _____ ID #: _____ Effective Date: _____

Subscriber: _____ Subscriber DOB: _____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION (if applicable):

Plan Name: _____ ID #: _____ Effective Date: _____

Subscriber: _____ Subscriber DOB: _____ Relationship to Patient: _____

Pediatric Associates of Brockton will submit medical claims to the insurance company based on my provided information I have provided. I understand that I am responsible for updating insurance information each time services are rendered. If this insurance information is not correct, I understand that I will be responsible for any charges. I further understand that Pediatric Associates of Brockton has privacy policies and financial policies in place. I have been offered the opportunity to read and receive a copy of Pediatric Associates of Brockton's Notice of Privacy Practices and Financial Policy.

Parent/Legal Guardian Signature: _____ Relationship to Patient: _____ Date: _____

Please list other children's names and dates of birth on the reverse side of this paper.

For Office Use Only ☐ Scanned ☐ Account Updated & Scanned (initials): _____ Date: _____ / ☐ Scanned & Given to Billing initials: _____ Date: _____

PATIENT DEMOGRAPHIC FORM CONTINUED

PATIENT INFORMATION:

Child's Name: _____ DOB: _____ ☐ Male / ☐ Female / Other _____

Child's Name: _____ DOB: _____ ☐ Male / ☐ Female / Other _____

Child's Name: _____ DOB: _____ ☐ Male / ☐ Female / Other _____

Child's Name: _____ DOB: _____ ☐ Male / ☐ Female / Other _____

Child's Name: _____ DOB: _____ ☐ Male / ☐ Female / Other _____

Child's Name: _____ DOB: _____ ☐ Male / ☐ Female / Other _____