PATIENT DEMOGRAPHICS

Patient Information

Patient's First Name _____Middle_____ Last_____

Nickname_____ Male____ Female____ Birth Date ____ / ____ / ____ Primary Physician _____

Parent 1 Name_____ Date of Birth_____

Parent 2 Name_____ Date of Birth_____

Home Address_____City_____State_____Zip Code_____

Are the home address and billing address the same? ☐ Yes ☐ No (Enter billing address below)

Billing Name_____ Billing Address_____

City_____State_____Zip Code_____

Email Address_____ Owner of Email_____

Primary Phone Number_____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

2nd Phone Number_____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

3rd Phone Number_____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

4th Phone Number_____ Home_____ Mom Cell_____ Dad Cell_____ Other_____

☐ I authorize North Seattle Pediatrics to leave a detailed message on my voicemail.
☐ I **do not** authorize North Seattle Pediatrics to leave a detailed message on my voicemail.

☐ I give permission for North Seattle Pediatrics to text me a message to call back.

Ethnicity: Hispanic/Latino_____ Not Hispanic/Latino_____ Prefer not to answer_____

Race: White_____ American Indian/Alaskan Native_____ Asian_____ Black/African American_____ Native HI/Pacific IS_____ Prefer not to answer_____

Preferred Language _____ Other Language _____

Do you need an interpreter? Yes_____ No_____ What Language? _____

Insurance Information

Primary Insurance Name _____ Copay _____

ID Number_____ Group Number _____

Subscriber's Name_____ Birth Date _____ Start Date _____

Employer_____

Secondary Insurance Name _____ Copay _____

ID Number _____ Group Number _____

Subscriber's Name _____ Birth Date _____ Start Date _____

Employer_____

Insurance Authorization and Assignment (Please read and Sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my visits to my insurance carrier. **I understand that I am responsible for my entire bill unless this form is complete.**

Parent/Guardian/Patient Signature_____Date_____