PATIENT DEMOGRAPHICS

Patient Information

Patient's First Name____________________ Middle_______________ Last____________________ Birth Date____________

Preferred Name_______________________ Nickname______________________ Primary Physician_____________________

Gender at Birth: Male___ Female___ Identifies as: Male ___ Female ___ Other ________ Preferred Pronouns _____________

Parent 1 Name____Date of Birth__________________

Parent 2 Name____Date of Birth__________________

Patient lives with: Name(s)_______________________________________ Relationship(s)_____________________________

Patient lives at____
Street Address City State Zip Code

Bills are sent to ____
Name Street Address City State Zip Code

Email Address____ Owner of Email Address_______________________________

Primary Phone Number_________________________________ Owner of Phone Number_______________________________

2nd Phone Number_____________________________________ Owner of Phone Number_______________________________

3rd Phone Number_____________________________________ Owner of Phone Number_______________________________

4th Phone Number_____________________________________ Owner of Phone Number_______________________________

- ☐ 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__________________________

Sign by typing your name for electronically submitted form