SOUTHWEST CHILDREN'S CLINIC LLC

DEMOGRAPHIC AND INSURANCE INFORMATION

Today's Date: ______________________ Patient's DOB: ______________________

Patient's Legal Name: ____

Address: ____

City: ____________________ State: __________ Zip: ______________

Home Phone Number: ______________________

Who does the patient live with? ______________________________________

Primary Language Spoken in Home: ______________ Secondary Language: ______________________

Ethnicity (circle one):

Hispanic/Latino

Not Hispanic/Latino

Unknown

Race (circle one):

American Indian/Alaskan Native

Asian

Black

White

Pacific Islander/ Hawaiian Native

Parent's Marital Status (please circle one):

Married Single Mother Single Father Divorced, Shared Custody Divorced, Sole Custody Mother/Father

Two Mother's Two Father's Grandparent as Guardian Foster Care Other: ____________

Mother's Name: ______________________________ Mother's DOB: ______________

Biologic Foster Adoptive Other: ______________

Mother's Address (if different from patient's): ______________________________________

Mother's Primary Phone Number (circle one): Home Cell ______________________

Mother's SSN: _ _ _ - _ _ - _ _ _ _ Mother's Email: ______________________________

Father's Name: ______________________________ Father's DOB: ______________

Biologic Foster Adoptive Other: ______________

Father's Address (if different from patient's): ______________________________________

Father's Primary Phone Number (circle one): Home Cell ______________________

Father's SSN: _ _ _ - _ _ - _ _ _ _ Father's Email: ______________________________

Emergency Contact (other than parent): ______________________________________

Relationship to child: ____________ Cell/Home Phone: ______________________

TURN OVER ->

Insurance Info:

Primary Insurance Name: ____

Member ID Number: ___________________________________

Primary Insurance Holder's Name: ____

Insurance Holder's DOB: __________________ Relationship to Patient: ____________________________________

Insurance Holder's SSN: ____________________

Insurance Holder's Place of Employment: ____

Secondary Insurance Name: ____

Member ID Number: ___________________________________

Secondary Insurance Holder's Name: ____

Insurance Holder's DOB: ________________ Relationship to Patient: _______________________________________

Insurance Holder's SSN: ______________________

Insurance Holder's Place of Employment: ____