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: _____