DR Q Pediatrics

Patient Demographic Form

Patient/Child Information

Child's Name ____________________________ Male___ Female________ DOB___________

Child resides with: ________Both Parents _____ father _______ Mother ______Other

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Mother's Name_____________________________________ DOB: _________________________

Home Address ____________________________________City, State, Zip___________________

Home Phone _________________* Cell Phone ______________Work# ________________

E-mail Address ____

Father's Name: ____DOB:__________________

Home Address: ______________________________________City, State,Zip ____________

Home Phone: __________________ *Cell Phone:_____________ Work# _______________

E-mail:____

Insurance Information

Primary insurance:___________________ Member ID: __________________
Group#:______________

Subscriber Name: ____________________________ Relationship to patient:_______________

Subscriber Employer:____

Subscriber Social Security:______________________ Subscriber DOB_____________________

***Emergency Contact:**

Name: ____

Relationship: ____

Home/Cell Phone: ________________________ Refused ________________________

Pharmacy Information

Name: ____

Phone: ____

Address: ____

Fax: ____

Messages (unless requested otherwise, we only leave our name/phone and general message regarding appointments, billing and diagnostic results.

OK to leave a detailed message at home? ___Yes ___ No

OK to leave email, text to confirm appointments ____Yes ___No

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Dr Q Pediatrics; I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

By signing below, I certify that I have read and understand the HIPPA Notice of Privacy Practices, Which explains how my medical information will be used and disclosed.

____ Date____

Parent/Guardian Signature