TODAY'S DATE: ___________________

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION:

Child's Name: ______________________________ DOB: ______________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):_______________

Child's Name: ______________________________ DOB: ______________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):_______________

Child's Name: ______________________________ DOB: ______________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):_______________

Child's Name: ______________________________ DOB: ______________ ❑ Male / ❑ Female Patient Cell # (16yr & ↑):_______________

PARENT / LEGAL GUARDIAN #1 -*LIVING IN SAME HOUSEHOLD AS PATIENTS & PRIMARY CONTACT FOR APPOINTMENT REMINDERS

Name: _________________________________ DOB: _____________ Relationship to Patient: ______________________

Address: ____ City / State / Zip: ___________________________________

Primary Phone #: _______________________ ☐ Cell ☐ Home ☐ Other__________

Alternate Phone #: ______________________ ☐ Cell ☐ Home ☐ Other__________

Occupation: ______________________________________ Employer: ____

Email: ____ ❑ I agree to receive email & text notifications from Legacy Pediatrics

PARENT / LEGAL GUARDIAN #2

Name: _________________________________ DOB: _____________ Relationship to Patient: ______________________

Address: ____ City / State / Zip: ___________________________________

Primary Phone #: _________________________ ☐ Cell ☐ Home ☐ Other _________

Alternate Phone #: _______________________ ☐ Cell ☐ Home ☐ Other _________

Occupation: ______________________________________ Employer: ____

Email: ____ ❑ I agree to receive email & text notifications from Legacy Pediatrics

PARENTS / LEGAL GUARDIANS (please circle): **Married Living Together Single Widowed Separated Divorced**

If Divorced or Separated, who is the Custodial Parent? ______________________________________

******PLEASE NOTE*: LEGAL DOCUMENTATION WILL BE REQUIRED FOR ANY CUSTODY ARRANGEMENTS. *

PRIMARY INSURANCE: Billing Address & Responsible Party for Billing Issues: ❑ **Parent/Guardian #1** ❑ **Parent/Guardian #2**

Plan Name: ________________________________ ID #: __________________________ Effective Date: ________________

Subscriber: _____________________________ Subscriber DOB: _____________ Relationship to Patient: ________________

SECONDARY INSURANCE INFORMATION (if applicable):

Plan Name: ________________________________ ID #: __________________________ Effective Date:___________________

Subscriber: ___________________________ Subscriber DOB: ___________ Relationship to Patient: ______________________

Legacy Pediatrics will submit medical claims to the insurance company based on the information I have provided. I understand that I am responsible for updating insurance information each time services are rendered. If this insurance information is not correct, I understand that I will be responsible for any charges. I further understand that Legacy Pediatrics has privacy policies and financial policies in place. I have been offered the opportunity to read and receive a copy of Legacy Pediatrics' Notice of Privacy Practices and Financial Policy.

Parent/Legal Guardian Signature: ____________________________ **Relationship to Patient**: ________________________ Date: __________