FAIRVIEW PEDIATRICS, LLC

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PATIENT DEMOGRAPHICS FORM

Please fill out every blank space. If not applicable, write NA in the space.

Today's Date: _____

Patient Information		
Name:		D.O.B:
Street Address:		Gender:
City:	State:	Zip Code:
☐ Home phone:	☐ Work phone:	☐ Cell phone:
Please check the box next to preferred phone number		
Email:		
Pharmacy:		
Race: ☐ Caucasian ☐ Black/African American ☐ Hawaiian/Pacific ☐ Declined ☐ Asian ☐ American Indian ☐ Other:		
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Declined:		
Primary Care Provider (in this office):		

Parent/Guardian Information (Parent #1):		
Name:		D.O.B.**: (Required):**
Relationship to Patient:		
Street Address:		
City:	State:	Zip code:
☐ Home phone:	☐ Work phone:	☐ Cell phone:
Please check the box next to preferred phone number		

Parent/Guardian Information (Parent #2):		
Name:		D.O.B.**: (Required):**
Relationship to Patient:		
Street Address:		
City:	State:	Zip code:
☐ Home phone:	☐ Work phone:	☐ Cell phone:
Please check the box next to preferred phone number		

Please list anyone who is authorized to bring patient to appointments, include relationship and phone number:

Please list who is Financially Responsible:		
☐ Parent #1 ☐ Parent #2 ☐ Other (Please list information below)		
Name:	**DOB:**	
Address: ☐ same as patient	**City**	**State/Zip**
Home Phone:	**Work Phone:**	**Cell Phone**
Relationship to Patient:		

Patient Insurance:		
Insurance Company Name		Effective Date:
Policy #:		Group #:
Subscriber/Policy Holder:		D.O.B.:
Relationship to Patient:		
Address:		
City:	State:	Zip
Phone Number:		
Is this patient covered by another insurance? ☐ **Yes** (If yes please complete below) ☐ **No** (Skip To Next Section)		
Second Insurance company:		Effective Date:
Policy #:		Group #:
Subscriber/Policy Holder**:**		D.O.B.:
Relationship to Patient:		
Phone Number:		

Insurance Assignment of Benefits Authorization and Policyholder Responsibilities

Please read carefully and sign, below:

I hereby authorize Fairview Pediatrics to

(1) Furnish requested medical information to relevant insurance carriers and health plans:

(2) furnish information to other relevant health care providers involved in the care of the patient. Furthermore, I hereby irrevocably assign to **Fairview Pediatrics** all payments from insurers/health plans for medical services rendered**.**

I understand and agree that:

(1) it is my responsibility to provide complete, accurate and current insurance/health plan information:

(2) as parent or guardian seeking care for this patient, I am financially responsible for all charges whether or not covered by insurance or otherwise;

(3) payment for all visits and copayments are due at the time service is rendered.

PLEASE PROVIDE INSURANCE CARD TO RECEPTIONIST

Signature:	**Date:**
Printed Name:	

PLEASE RETURN THIS FORM TO RECEPTIONIST