PATIENT DEMOGRAPHICS

Patient Information

Patient's First Name____________________________ Middle_________________________ Last___________________________

Nickname_________________________Male___Female___ Birth Date____/____/____Primary Physician____________________

Parent 1 Name____Date of Birth______/______/______

Parent 2 Name____Date of Birth______/______/______

Patient lives with: Name(s)____ Relationship(s)______________________________

Patient lives at____
Street Address City State Zip Code

Bills are sent to____
Name Street Address City State Zip Code

Email Address____ Owner of Email Address________________________________

Primary Phone Number__________________________________ Owner of Phone Number________________________________

2nd Phone Number______________________________________ Owner of Phone Number________________________________

3rd Phone Number______________________________________ Owner of Phone Number________________________________

4th Phone Number______________________________________ Owner of Phone Number________________________________

☐ I authorize North Seattle Pediatrics to leave a detailed message on my voicemail.
☐ I **do not** authorize North Seattle Pediatrics to leave a detailed message on my voicemail.
☐ I give permission for North Seattle Pediatrics to text me a message to call back.

Ethnicity: Hispanic/Latino______ Not Hispanic/Latino______ Prefer not to answer______

Race: White_____ American Indian/Alaskan Native_____ Asian_____ Black/African American_____ Native HI/Pacific IS_____ Prefer not to answer_____

Preferred Language____ Other Language__________________________________

Do you need an interpreter? Yes________ No________ What Language?____

Insurance Information

Primary Insurance Name____ Copay____________________

ID Number____ Group Number_________________________________

Subscriber's Name____ Birth Date_______________ Start Date_______________

Employer____

Secondary Insurance Name____ Copay____________________

ID Number____ Group Number_________________________________

Subscriber's Name____ Birth Date_______________ Start Date_______________

Employer____

Insurance Authorization and Assignment (Please read and Sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my visits to my insurance carrier. **I understand that I am responsible for my entire bill unless this form is complete.**

Parent/Guardian/Patient Signature____Date___________________________