



FAMILY DEMOGRAPHIC INFORMATION

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ MI: \_\_\_\_\_  
Birth date (mm/dd/yyyy): \_\_\_\_\_ Gender: M / F Social Security No.: \_\_\_\_\_  
Home: Street Address \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ May we leave voice messages at these numbers? \_\_\_\_\_

Mother: \_\_\_\_\_  
Natural Adoptive Step-parent Legal Guardian  
Birth date: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security No.: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_  
Business phone: \_\_\_\_\_

Father: \_\_\_\_\_  
Natural Adoptive Step-parent Legal Guardian  
Birth date: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security No.: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_  
Business phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Ins. Co. and Plan Type: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Ins. Co. and Plan Type: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Please list any additional guardians (*if different from above*): (*Must sign Designated Representative form.*)  
\_\_\_\_\_

Who is the Guarantor (*financially responsible person*) for this patient's account (*if different from above*):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Phone: \_\_\_\_\_  
Home address: \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security No.: \_\_\_\_\_

I authorize PETITE PEDIATRICS and/or their agent to bill, receive, release, and exchange information with my insurance carrier.

**Patient or parent/Legal guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Print patient or parent/Legal guardian name:** \_\_\_\_\_