

Kid's Way Pediatrics
Patient Demographic Sheet
Please complete in entirety

Patient Information:

Patient Name: _____ D.O.B. _____
Sex: M / F Social Security #: ____-____-_____
Address: _____
Home Phone #: (____) ____-_____
Siblings: _____

Responsible Party Information:

Mother's Name: _____ D.O.B. _____
Address: _____
Social Security #: ____-____-_____
Home Phone #: (____) ____-____ Work Phone #: (____) ____-____
Father's Name: _____
Address: _____
Social Security #: ____-____-_____
Home Phone #: (____) ____-____ Work Phone #: (____) ____-____

Emergency Contact (other than parent)

Name: _____ Relationship: _____
Address: _____
Phone: (____) ____-_____

Insurance Information:

Primary Insurance Name: _____
Address: _____
Phone #: (____) ____-_____
Policy Holder's Name: _____ Effective Date: _____
Policy #: _____ Group #: _____
Employer: _____ Copay \$: _____

Secondary Insurance Name: _____
Address: _____
Phone #: (____) ____-_____
Policy Holder's Name: _____ Effective Date: _____
Policy #: _____ Group #: _____
Employer: _____ Copay \$: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of Government or Insurance benefits either to myself or the party who accepts assignment below. I also authorize payment of medical benefits to the undersigned physician or supplier for services described herein. I also understand I am financially responsible for all charges not covered by this authorization and guarantee payment on this account.

Signed: _____ Date: _____

It is the responsibility of the patient to notify the office of any and all insurance changes. If complete billing information is not available at the time of service, the claim will be made self pay until information is provided.