Amherst Pediatrics Patient Demographic Form

In order to serve you properly, we will need the following information. All information is confidential. **Please Print.**

Patient Name_____ Nickname_____ DOB _____

Address _____

City _____ State _____ Zip_____ Male ___ Female___

Preferred Email: _____ Preferred Language: _____

Main Contact Phone:_____ __Home __Cell __Other (please specify)_____

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Native
- ☐ White
- ☐ Other:_____
- ☐ Declined

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined

Preferred Pharmacy: _____

City: _____

Street: _____

Other children who are seen here with the **same address and insurance, please put on back of form**

Parent or Guardian Contact Information

(if there are more than 2 contacts, please use back side of form for more)

Name _____

Relationship to Patient _____

Tel (H) _____ (W) _____

Cell _____ Preferred: H W C

Email _____

Legal Guardian: ☐ Yes ☐ No

Address (if different)_____

_____

Name _____

Relationship to Patient _____

Tel (H) _____ (W) _____

Cell _____ Preferred: H W C

Email_____

Legal Guardian: ☐ Yes ☐ No

Address (if different)_____

_____

Emergency Contact **(other than parent)** _____ Phone _____ Relationship to Patient_____

Insurance Information

Name of Primary insurance _____ ID # _____

Subscriber or Policy Holder's name _____ Date of birth _____

Person financially responsible for this account _____

Relationship to patient _____ Phone (H) _____ (W) _____

*If you have **secondary insurance** coverage, please complete on back of form*

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company necessary to process insurance claims for services rendered by the practitioners of Amherst Pediatrics, LLP. I hereby authorize the above insurance company(ies) to distribute the payment of my dependent's medical coverage directly to the provider rendering services. I authorize the use of this signature on all insurance submissions. I will pay Amherst Pediatrics for all charges incurred if the patient(s) above is (are) not eligible for the stated insurance plan or: (1) These services are normally provided by my primary care physician and I decided to request services from Amherst Pediatrics who is not my primary care physician. (2) These services were not authorized by my primary care physician with a written in-plan referral form. (3) These services exceed my benefit limitation. I acknowledge that I have voluntarily sought the services of Amherst Pediatrics.

Signature _____ Date _____

***Secondary Insurance Information (if applicable)**

Name of Secondary insurance _____ ID # _____

Subscriber or Policy Holder's name _____ Date of birth _____

Person financially responsible for this account _____

Relationship to patient _____ Phone (H) _____ (W) _____

Is this secondary insurance for all children listed? Y N

If no, which child(ren) _____

****Additional children** who are seen here with the **same address and insurance information (if applicable)**

Name _____ Nickname_____ DOB _____ ___ Male ___ Female

Name _____ Nickname_____ DOB _____ ___ Male ___ Female

Name _____ Nickname_____ DOB _____ ___ Male ___ Female

Name _____ Nickname_____ DOB _____ ___ Male ___ Female

Name _____ Nickname_____ DOB _____ ___ Male ___ Female

Name _____ Nickname_____ DOB _____ ___ Male ___ Female

*****Additional Parent/Guardian Contact Information (if applicable)**

Name _____

Relationship to Patient _____

Tel (H) _____ (W) _____

Cell _____ Preferred: H W C

Email _____

Legal Guardian: ☐ Yes ☐ No

Address (if different)_____

Name _____

Relationship to Patient _____

Tel (H) _____ (W) _____

Cell _____ Preferred: H W C

Email_____

Legal Guardian: ☐ Yes ☐ No

Address (if different)_____