

Patient Demographic/Insurance Form - (under 18)

Patient Name: _____ DOB: ____ / ____ / ____
First Middle Last

Patient Information

Address: _____
Street Address City State Zip

Mailing Address (if different from address above):

Street Address City State Zip

Gender: M / F Email: _____ Cell: _____

Sibling: _____ DOB: _____ Resides w/ Patient: Y / N

Sibling: _____ DOB: _____ Resides w/ Patient: Y / N

Sibling: _____ DOB: _____ Resides w/ Patient: Y / N

Patient Resides With: Father Mother Other (relationship) _____

School Child Attends: _____ Grade: _____

#1 Parent/Guardian Information Name: _____

Address: _____
Street Address City State Zip

Mailing Address (if different from address above):

Street Address City State Zip

Cell Phone : _____ Text: Y / N Home Phone: _____

Email: _____

Preferred method of contact: Cell call Cell text Home call Email

#2 Parent/Guardian Information Name: _____

Address: _____
Address City State Zip

Mailing Address (if different from address above):

Street Address City State Zip

Cell Phone : _____ Text: Y / N Home Phone: _____

Email: _____

Preferred method of contact: Cell call Cell text Home call Email

FLATON ADDEPT CENTER

San Luis Obispo, California 93401

Patient Demographic/Insurance Form - (under 18)

Patient Name: _____ **DOB:** ____ / ____ / ____

_____ First Middle Last

Primary Care Pediatrician

Primary Care Pediatrician: _____

Office Phone Number: _____ Fax Number: _____

Address: _____

Street Address City State Zip

Primary Insurance Provider: _____

Insured's Name: _____ Male Female

Relationship to Patient: Self Parent/Guardian Spouse Child Other Insured's DOB: ____ / ____ / ____

Member ID Number: _____ Group Number: _____

Secondary Insurance Provider: _____

Insured's Name: _____ Male Female

Relationship to Patient: Self Parent/Guardian Spouse Child Other Insured's DOB: ____ / ____ / ____

Member ID Number: _____ Group Number: _____

Emergency Contact:

Name: _____ DOB: ____ / ____ / ____

Relationship to Patient: Parent/Guardian Spouse Child Other _____

Phone Number: _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Responsible Party for Financial Payment

Name: _____ DOB: _____

Relationship to Patient: Parent/Guardian Spouse Child Other _____

Phone Number: _____ Email: _____

Address: _____

Street Address City State Zip

Social Security # _____ - _____ - _____

Responsible party signature _____ Date: _____