WAVERLY HEALTH CENTER

Pediatric Patient Demographics

(Ages 17 and Under)

Date: _____ Family Doctor: _____

Patient's Name: _____
First Middle initial Last

Birth Date: _____ Social Security #: _____

Physical Address: _____
Street City State County Zip

Mailing Address: □ Same as above _____
Street City State County Zip

Home Phone: _____ Cell Phone: _____

Other Demographic Information

Sex: □ Male □ Female **Preferred Language:** _____

Race: □ Asian □ Black □ Caucasian □ Hawaiian/Pacific Islander □American Indian/Alaska Native
□Hispanic □ Decline to Answer □ Other

Ethnicity: □Hispanic □Non-Hispanic □Decline to Answer

Parent Information

Father's Name: _____ Date of Birth: _____
Marital Status: _____ Home Phone: _____
Address: □ Same as patient _____ Email Address: _____
Mother's Name: _____ Date of Birth: _____
Marital Status: _____ Home Phone: _____
Address: □ Same as patient _____ Email Address: _____

Person other than Parents to Contact in an Emergency

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Insurance Information

Policy Holder: _____ Policy Holder: _____
Policy Holder Birth Date: _____ Policy Holder Birth Date: _____
Primary Insurance: _____ Secondary Insurance: _____
Member Number: _____ Member Number: _____
Group Number: _____ Group Number: _____
Claims Address: _____ Claims Address: _____
Phone Number: _____ Phone Number: _____

Guarantor/Person Responsible for Charges

Name: _____ Phone: _____

Signature: _____ Date: _____