

**PATIENT DEMOGRAPHIC SHEET**

**PLEASE PRINT (List all children separately, Circle parent that each child lives with, turn over for additional information)**

**Child (1) Full Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Gender** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Grp#** \_\_\_\_\_ **Copay \$** \_\_\_\_\_

**Subscriber Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Grp#** \_\_\_\_\_ **Copay \$** \_\_\_\_\_

**Subscriber Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Mother/Father Full Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Marital Status** \_\_\_\_\_

**Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_

**Hm Phone #** \_\_\_\_\_ **Wk Phone #** \_\_\_\_\_ **Cell Phone #** \_\_\_\_\_

**Employer Name/Address** \_\_\_\_\_

**Father/Mother Full Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Marital Status** \_\_\_\_\_

**Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_

**Hm Phone #** \_\_\_\_\_ **Wk Phone #** \_\_\_\_\_ **Cell Phone #** \_\_\_\_\_

**Employer Name/Address** \_\_\_\_\_

<p>Child is eligible for immunizations through the federal VFC Program because he/she is:  <input type="checkbox"/> American Indian (Native American) or <input type="checkbox"/> Alaska Native          American) or</p> <p><b>Ethnicity:</b> <input type="checkbox"/> <b>Hispanic</b> <input type="checkbox"/> <b>Non-Hispanic</b> <input type="checkbox"/> <b>Refuse to Report</b></p>	<p>Child is <i>not</i> VFC eligible because he/she has:  <input type="checkbox"/> health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native          Alaska Native</p> <p><b>Race:</b> _____</p>
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**Child (2) Full Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Gender** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Primary Insurance** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Grp#** \_\_\_\_\_ **Copay \$** \_\_\_\_\_

**Subscriber Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Grp#** \_\_\_\_\_ **Copay \$** \_\_\_\_\_

**Subscriber Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Mother/Father Full Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Marital Status** \_\_\_\_\_

**Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_

**Hm Phone #** \_\_\_\_\_ **Wk Phone #** \_\_\_\_\_ **Cell Phone #** \_\_\_\_\_

**Employer Name/Address** \_\_\_\_\_

**Father/Mother Full Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_ **Marital Status** \_\_\_\_\_

**Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_

**Hm Phone #** \_\_\_\_\_ **Wk Phone #** \_\_\_\_\_ **Cell Phone #** \_\_\_\_\_

<p>Child is eligible for immunizations through the federal VFC Program because he/she is:  <input type="checkbox"/> American Indian (Native American) or <input type="checkbox"/> Alaska Native          American) or</p> <p><b>Ethnicity:</b> <input type="checkbox"/> <b>Hispanic</b> <input type="checkbox"/> <b>Non-Hispanic</b> <input type="checkbox"/> <b>Refuse to Report</b></p>	<p>Child is <i>not</i> VFC eligible because he/she has:  <input type="checkbox"/> health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native          Alaska Native</p> <p><b>Race:</b> _____</p>
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Child (3) Full Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_ SS# \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_ Copay \$ \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_ Copay \$ \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Mother/Father Full Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone # \_\_\_\_\_ Wk Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Father/Mother Full Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone # \_\_\_\_\_ Wk Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

<p>Child is eligible for immunizations through the federal VFC Program because he/she is:  <input type="checkbox"/> American Indian (Native American) or <input type="checkbox"/> Alaska Native          American) or</p> <p><b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refuse to Report</p>	<p>Child is <i>not</i> VFC eligible because he/she has:  <input type="checkbox"/> health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native          Alaska Native</p> <p><b>Race:</b> _____</p>
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Child (4) Full Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_ SS# \_\_\_\_\_

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_ Copay \$ \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Grp# \_\_\_\_\_ Copay \$ \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Mother/Father Full Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone # \_\_\_\_\_ Wk Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Father/Mother Full Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Hm Phone # \_\_\_\_\_ Wk Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

<p>Child is eligible for immunizations through the federal VFC Program because he/she is:  <input type="checkbox"/> American Indian (Native American) or <input type="checkbox"/> Alaska Native          American) or</p> <p><b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refuse to Report</p>	<p>Child is <i>not</i> VFC eligible because he/she has:  <input type="checkbox"/> health insurance (that covers all recommended childhood and adolescent vaccinations) and is not American Indian (Native          Alaska Native</p> <p><b>Race:</b> _____</p>
<p><b>I authorize the release of my child's/children's medical information necessary to process this claim.</b></p> <p><b>I authorize the release of payment of medical benefits to my child's/children's physician.</b></p> <p><b>I understand that I am financially responsible for payment of service not covered by my insurance company.</b></p> <p><b>I have received a copy of Pediatric Associate's HIPAA privacy act.</b></p>	
<p><b>Parent/Guardian Signature</b> _____ <b>Date:</b> _____</p>	