- Pediatric Demographics -

Date _____

Patient's Last Name	First	Middle Initial	Date of Birth	Sex	Social Security Number

Street Address	City	State / Zip Code

Home Telephone Number ( )	Cell Phone No. for _____ ( )	Message Telephone Number ( )

Parent/Guardian	Parent/Guardian
Relationship ❑ Mother ❑ Father ❑ Foster Parent ❑ Legal Guardian	Relationship ❑ Mother ❑ Father ❑ Foster Parent ❑ Legal Guardian
Parent's Date of Birth / Parent's Social Security Number	Parent's Date of Birth / Parent's Social Security Number
Parent's Address (if different from patients)	Parent's Address (if different from patients)
Parent's Employer	Parent's Employer
Parent's Work Phone Number	Parent's Work Phone Number
Parent's Email Address	Parent's Email Address

Local Contact for Emergencies	Relationship to Patient	Emergency Contact Telephone Number ( )

Race	May Choose More than One. Circle Top Choice. ❑ White ❑ Black / African American ❑ Native Hawaiian ❑ Choose not to disclose ❑ Asian ❑ American Indian / Alaska Native ❑ Other Pacific Islander ❑ Other_____
Ethnicity	May Choose More than One. Circle Top Choice. ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported/Choose not to disclose
Language	❑ English ❑ Spanish ❑ Burmese ❑ Other_____

Do you need help finding a place to live? ❑ Yes ❑ No

Insurance Information ❑ No Insurance Coverage

❑ Medicaid	Medicaid Number			
❑ Other	Insurance Name	Group Number	Policy Number	
	Subscriber/Employee	Patient is: ❑ Subscriber ❑ Spouse ❑ Dependent	Subscriber's Date of Birth	Subscriber's Social Security Number
❑ Other	Insurance Name	Group Number	Policy Number	
	Subscriber/Employee	Patient is: ❑ Subscriber ❑ Spouse ❑ Dependent	Subscriber's Date of Birth	Subscriber's Social Security Number

❑ Yes ❑ No	Grace Health offers discounted fees to those who qualify. If you would like information about our Schedule of Discounts Program, please mark "Yes".

Reporting yearly household income is a government requirement that will allow Grace Health to continue to receive funding to provide special services for our patients. Please support these programs by selecting your income range.

Please choose one income level that best describes your total household income: Number of people living in home _____

❑ 0 - $25,999 ❑ $26,000 - $50,999 ❑ $51,000 - $75,999 ❑ $76,000+ ❑ Do not want to answer