

## Pediatric Demographics

Date \_\_\_\_\_

Patient's Last Name	First	Middle Initial	Date of Birth	Sex	Social Security Number
Preferred Name					
Street Address			City		State / Zip Code
Home Telephone Number ( )		Cell Phone No. for _____ ( )		Message Telephone Number ( )	
Parent/Guardian			Parent/Guardian		
Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian			Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster Parent <input type="checkbox"/> Legal Guardian		
Parent's Date of Birth		Parent's Social Security Number		Parent's Date of Birth	
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. <input type="checkbox"/> White <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Asian <input type="checkbox"/> Chinese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other _____				
Ethnicity	May Choose More than One. Circle Top Choice. <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/o <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Spanish <input type="checkbox"/> Unreported/Choose not to disclose				
Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Burmese <input type="checkbox"/> Other _____				
Do you need help finding a place to live? <input type="checkbox"/> Yes <input type="checkbox"/> No					

### Insurance Information    No Insurance Coverage

<input type="checkbox"/> Medicaid	Medicaid Number				
<input type="checkbox"/> Other	Insurance Name		Group Number	Policy Number	
	Subscriber/Employee		Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Subscriber's Date of Birth	Subscriber's Social Security Number
<input type="checkbox"/> Other	Insurance Name		Group Number	Policy Number	
	Subscriber/Employee		Patient is: <input type="checkbox"/> Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> 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 size and 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 providing the following information:**

*Number of people living in home:* \_\_\_\_\_ *Total household income:* \_\_\_\_\_ *Choose not to disclose:* \_\_\_\_\_