Genesee-Transit Pediatrics Patient Demographic Form (Patients 18yrs & older)

In order to serve you properly, we will need this form completed. All information is confidential.

Patient Name: _____ Birth Date: _____

Sex: ◯ Male ◯ Female Phone: (_____)_____

Address: _____City:_____ State: _____ Zip code: _____

Primary Language: _____ Country: _____

Secondary Language: _____Country: _____

Ethnicity: ◯ Spanish/Hispanic ◯ Not of Spanish/Hispanic ◯ Declined/Unknown

Ancestry: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Declined/Unknown

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What pharmacy do you typically use? _____ Phone: (____)_____

Patient's Employer (if any):_____ Phone: (____)_____

Emergency Contact

***Please note**-this does not allow the emergency contact to have access to medical or billing information whenever they call. This is to get a message to you if we have do not have any other way to get a hold of you.

1) _____/_____ 2) _____/_____

Emergency Contact (Relationship to patient) (phone number) **Emergency Contact** (Relationship to patient) (phone number)

_____ Date _____

(Signature of Legal Guardian)

I give permission for the Emergency Contact to have access to Medical and/or Billing information. ◯ Yes ◯ No

Administrative use-Staff initials and date:_____

Insurance Information (Patients 18yrs & older)

Are you under your parent's insurance?: ◯ N/A ◯ Yes ◯ No ◯ I have my own coverage

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Name of Subscriber: _____ Birth Date: _____

Secondary Insurance Company: _____

Policy #: _____ Group #: _____

Name of Subscriber: _____ Birth Date: _____

It is your responsibility to provide accurate and up to date medical insurance information to us and to notify us of any changes in your insurance coverage. You will be invoiced directly if your insurance denies coverage or if we do not have insurance changes/information that results in a timely filing denial.
You are responsible for and expected to pay promptly all copayments, coinsurance or unpaid deductibles at the time of service.

I, the undersigned, authorize the release of any medical or insurance information to the stated insurance company necessary to process insurance claims for the services rendered by the practitioners of Genesee-Transit Pediatrics, LLP. I hereby authorize the above insurance company to distribute the payment of my medical coverage directly to the provider rendering services.

_____

Print Name

_____ Date _____

Signature

Administrative use-Staff initials and date:_____