Genesee-Transit Pediatrics Patient Demographic Form

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

Relationship between Mother and Father: ◯ Married ◯ Separated ◯ Divorced ◯ Other

Who has legal custody of this patient? _____

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

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

Parent:

◯ Mother ◯ Step-Mother ◯ Guardian ◯ Other-If other indicate relationship: _____

Name: _____ Maiden Name (Immunization Registry):_____

Address: _____ City: _____ State: _____ Zip code: _____

Birth Date: _____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Employer: _____ Phone: (_____)_____

Parent:

◯ Father ◯ Step-Father ◯ Guardian ◯ Other-If other indicate relationship: _____

Name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Birth Date: _____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Employer: _____ Phone: (_____)_____

I hereby request and authorize Genesee-Transit Pediatrics to provide and perform such medical / surgical care, tests, procedures, medications, and other healthcare services as are considered necessary or beneficial for my child's health and well being.

_____ Date _____

(Signature of Parent/ Legal Guardian)

Administrative use-Staff initials and date:_____

Insurance Information

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 co-payments, co-insurance or unpaid deductibles at the time of service. The person bringing in the child regularly is considered the responsible party regardless if they are the subscriber of the insurance.

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 dependent's medical coverage directly to the provider rendering services.

_____

Print Name of Parent/Legal Guardian

_____ Date _____

Signature of Parent/Legal Guardian

Emergency Contact

I further authorize (where applicable) the following relatives / friends to bring my child in for healthcare if I am not available.
***Please note**-this does not allow the emergency contact to have access to medical or billing information whenever they call. This is for sick visits and/or a way to contact 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:_____