Ballentine Pediatrics Demographic Questionnaire

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Office 803-732-0920 Fax 803-227-2759

*****PLEASE COMPLETE ALL SECTIONS BELOW*****

Patient Information

Patient's Full Name _____Date of Birth _____/____/_____
First Middle Last

Address _____ Apt/Lot #_____City _____Zip _____

Home Phone # _____ Patient's SS# _____-_____-_____ Male or Female

Preferred Language_____ Ethnicity: ___Hispanic/Latino ___ Non Hispanic/Latino ___ Unknown

Race: _____ African American/Black _____ American Indian/Alaskan Native _____ Asian

_____ Native Hawaiian/Other Pacific Islander _____ White _____ Other Race

Parent Information

Father's Name _____ Date of Birth ____/____/____ SS# _____-_____-_____

Employer _____ Work #_____ Cell #_____

Mother's Name _____ Date of Birth: ____/____/____ SS# _____-____-_____

Employer _____ Work #_____ Cell #_____

Insurance Information

Primary Insurance _____ Effective Date ____/____/____ ID_____

Policy-Holder's Name: _____ Date of Birth: ____/____/____ Relationship to patient_____

Employer _____ Group #_____

Secondary Insurance _____ Effective Date ____/____/____ ID_____

Policy-Holder's Name: _____ Date of Birth: ____/____/____ Relationship to patient_____

Employer _____ Group #_____

Responsible Party Information

Responsible Party Name _____ Relationship to Patient _____

Address _____ Apt/Lot #_____City _____Zip _____

Home # _____ Work # _____ Cell # _____

Sibling Information (Brothers and Sisters) *If additional space is needed continue on the back of page.*

First Name	Last Name	Date of birth	Sex
First Name	Last Name	Date of birth	Sex
First Name	Last Name	Date of birth	Sex

I hereby authorize and assign payment of medical benefits to BALLENTINE PEDIATRICS, LLC for services rendered. I hereby authorize the release of any medical information necessary to process insurance claims. I acknowledge the responsibility to pay any debt incurred not covered by insurance.

_____

Signature Relationship to Patient Date

Thank you for allowing us to be a partner in your children's healthcare.