# Demographics Form

*Please notify our office promptly if any information below changes.*

**Child's First Name:** ____________________ **MI:** ________ **Last Name:** ___________________________

**Date of Birth** (mm/dd/yyyy)________________________**Gender** (Please Mark One)**:** ☐ M ☐ F

**Home Address:** ___________________________________________________________________________

*(Street)* *(City)* *(State)* *(Zip)*

**Patient currently resides with:**

☐ Both Parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parent

**<u>Patient Demographics</u>**:

The Federal Government requires all medical practices to collect the following information from patients.
*There is a provision in the law that allows patients to not answer these questions.*

1. My Child's Ethnicity is: (Please Select One)
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino
   - ☐ I decline to provide this information
2. My Child's Race is: (Please Select One)
   - ☐ American Indian/Alaskan Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Pacific Islander
   - ☐ White/Caucasian
   - ☐ Other
   - ☐ I decline to provide this information
3. My Child's Preferred Language is: (Please Select One)
   - ☐ English
   - ☐ Spanish
   - ☐ Other: ________________________
   - ☐ I decline to provide this information

**<u>Parent/Guardian Information:</u>**

NOTE: All guardianship, custody, and placement arrangements (including court-ordered foster care, kinship care, and legal custody agreements) must be documented in the patient's chart. Legal documentation (court orders or placement agreements) must be provided and kept on file at the time of the patient's first visit and whenever a change in arrangement occurs.

**Parent/Guardian 1 Name:** ____________________________________________ **DOB:** _____________________

**Phone Number:**___________________**(h)** ________________________**(c)** ______________________**(w)**

**Email Address:** _____________________________________________

**Occupation:** ___________________________________ **Employer:** ____________________________________

**Parent/Guardian 2 Name:** _____________________________________________ **DOB:** _____________________

**Phone Number:**_____________________**(h)** _____________________**(c)** ____________________**(w)**

**Email Address:** ______________________________________________

**Occupation:** ___________________________________ **Employer:** ____________________________________

**Who should be the primary contact for the patient?** ☐ Parent/Guardian 1 ☐ Parent/Guardian 2

**Service Payment Information:** ___ Check here if patient is Self Pay

**Primary Insurance:** __________________________ **Policy #:** ________________ **Group #:** _________

**Policyholder's Name:** __________________________ **DOB:** _______________ **SSN:** ________________

Secondary Insurance:_______________________ Policy #: ________________ Group #: ____________

Policyholder's Name: __________________________ DOB:________________ SSN: ________________

**Authorized Individuals:**

Please list anyone other than parents and legal guardians who may accompany the above listed patient to appointments, receive medical information/advice, and/or schedule appointments.

| | Contact Name | Contact Relationship | Contact Phone Number |
|---|---|---|---|
| Emergency Contact | | | |
| Contact #2 | | | |
| Contact #3 | | | |
| Contact #4 | | | |

I understand that any person who is not a legal guardian of my child or whose name does not appear on the Authorized Individuals list will not be given access to any medical information, will not be allowed to schedule appointments, or be allowed to accompany my child for treatment without further written permission. **Initial**: _______

**Consent to Treat**

I attest that I am the parent or legal guardian of the patient named above and have the authority to make healthcare decisions on behalf of my child. I hereby authorize the providers and clinical staff of South Carolina Pediatric Alliance to evaluate, examine, diagnose, and provide medical care and treatment to my child as deemed medically necessary by the provider. I understand that this consent includes routine care and any non-emergency treatment required during my child's visit. This consent will remain in effect unless revoked in writing.

**Name of Person completing form (Printed):** ______________________________________________

**Parent/Guardian Signature:** ________________________________________ **Date:** ______________