Sandhills PEDIATRICS

New Patient Demographic Form

Primary Doctor: _____

Child's Name: _____ Gender (Please Mark One): ____M ____F
(First) (Middle) (Last)

Date of Birth: _____ Place of Birth: _____
(mm / dd / yyyy) (City and State)

Home Address: _____
(Street) (City) (State) (Zip)

If you experience a move throughout our care for your child please update this information with your home office.

Mother/Guardian's Name: _____ **DOB**:_____ **SSN**: _____

Occupation: _____ Employer: _____

Home #:_____ **Cell #**:_____ **Alternate #**:_____

Primary Phone Number (Please Mark One): Home # ☐ Cell # ☐ Alternate # ☐

Email Address: _____

Father/Guardian's Name: _____ **DOB**:_____ **SSN**: _____

Occupation: _____ Employer: _____

Home #:_____ **Cell #**:_____ **Alternate #**:_____

Primary Phone Number (Please Mark One): Home # ☐ Cell # ☐ Alternate # ☐

Email Address: _____

Primary Insurance: _____ Policy Number:_____ Group #:_____

Policyholder's Name: _____ DOB:_____ SSN: _____

Secondary Insurance: _____ Policy Number:_____ Group #:_____

Policyholder's Name: _____ DOB:_____ SSN: _____

Sibling's Names and Dates of Birth:

1.) _____ DOB: _____ **4.)** _____ DOB: _____

2.) _____ DOB: _____ **5.)** _____ DOB: _____

3.) _____ DOB: _____ **6.)** _____ DOB: _____

Family History: (Please Circle Y or N and explain if indicated)

Allergies/Asthma	**Y / N**	If Yes, Please Explain	_____
Diabetes	**Y / N**	If Yes, Please Explain	_____
Hypertension	**Y / N**	If Yes, Please Explain	_____
Convulsive Disorders	**Y / N**	If Yes, Please Explain	_____
Sickle Cell	**Y / N**	If Yes, Please Explain	_____
Cardiovascular Disease	**Y / N**	If Yes, Please Explain	_____

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Child's Birth and Development History:

Born at (Name of Hospital): _____ **Birth Weight**: _____

Any Problems with pregnancy or delivery: _____

Full Term Birth? Y / N If No, How Many weeks at birth? _____

Type of Delivery (Please Select One): ☐ Vaginal ☐ C-Section

NICU (Please Select One): Y / N If Yes, Reason for NICU Hospitalization? _____

Hepatitis B Vaccine Date (if Newborn): _____

Any Chronic Illnesses: _____

Any Surgeries: _____

Current Medications: _____

Allergies (medicines, food, environmental): _____

School: _____ **Grade in School**: _____

Demographic Information

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.
Please answer the following three questions or select the "I decline to provide this information" answer.

1.) My Child's Ethnicity is: (Please Select One)
A. Hispanic or Latino
B. Not Hispanic or Latino

2.) My Child's Race is: (Please Select One)
A. American Indian/Alaskan Native
B. Asian
C. Black or African American
D. Native Hawaiian or Pacific Islander
E. White/Caucasian
F. Other

3.) My Child's Preferred Language is: (Please Select One)
A. English
B. Spanish
C. Other: _____
(Please Provide Preferred Language)

☐ I decline to provide this information

Emergency Contact

Name: _____ Phone Number: _____

Relationship to Patient: _____

Name of person filling out this form (printed): _____

Parent/Guardian Signature: _____ **Date:** _____