# Vestavia Pediatrics

## Patient Information Sheet

### Demographic Information

Patient ID #: ____________

First Name: ____________ Middle: ____________ Last Name: ____________

DOB: ____________ Sex: ____________ Suffix: ____________ Nickname: ____________

Primary Language: ____________

Federal regulations now require that we collect the following demographic information below.

Race: Please Circle

American/Indian/Alaska | Asian | White | Black/African American | Nat Hawaiian/Pacific Islander | Other Race

Are you of Hispanic/ Latino descent? YES / NO

### Contact Information

Mailing Address: ____________ City: ____________ State: ______ ZIP: ____________

Phone numbers (Please check the box next to the best number to reach you)

Home: ☐ ____________ Work: ☐ ____________ Cell: ☐ ____________

Email: ____________

Emergency Contact: ____________ Phone #: ____________

### Billing Information

For patients under 18 or who have a legal guardian:

Guardian: ____________ Address: ____________ Phone: ____________ DOB: ____________

Guardian: ____________ Address: ____________ Phone: ____________ DOB: ____________

Primary Ins: ____________ Address: ____________

Policy #: ____________ Group #: ____________

Policyholder: ____________ Relationship: ____________

DOB: ____________ Co-Pay ____________

Secondary Ins: ____________ Address: ____________

Policy #: ____________ Group #: ____________

Policyholder: ____________ Relationship: ____________

DOB: ____________ Co-Pay: ____________

Primary/Preferred Provider: ____________

Preferred Pharmacy (Name & City): ____________ Mail Order Pharmacy: ____________

I understand that I will be responsible for any co-insurance, deductible, or out of pocket expense not covered by my insurance. If any balance is not paid when due I understand that I will be responsible for the balance. I also understand that if the unpaid account is referred to an outside agency, I am responsible to pay all costs of collection including attorney fees. I hereby authorize the release of information to my insurance carrier or its intermediaries for all covered services rendered by Vestavia Pediatrics.

Signature: ____________ Date: ____________