KIDS FIRST
Pediatric Group, LLC

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NEW PATIENT DEMOGRAPHIC SHEET

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____
Preferred (Nickname):_____ Suffix: _____
Date of Birth: _____ Sex: _____ SS#: _____ Race: _____
Ethnicity: _____
Address: Line1: _____ Line2: _____
Zip: _____ City: _____ State: _____ County: _____
Phone: _____ mobile / home (circle one)
Referred by: _____

Preferred Pharmacy Name: _____ Address: _____
Pharmacy Number: _____

GUARANTOR INFORMATION

Parent/Guardian #1: ☐ Check if primary parent/guardian
Last Name: _____ First: _____ Middle: _____
Prefix: _____ Suffix: _____ Date of Birth: _____ SS#: _____
Relationship to Patient: _____ Martial Status: _____ Primary Language: _____
Address: Line1: _____ Line2: _____
Zip: _____ City: _____ State: _____ County:_____

Phone: Home: _____ Work: _____ Cell: _____
Email: _____

Employer: Name: _____
Address: _____

Parent/Guardian #2: ☐ Check if primary parent/guardian
Last Name: _____ First: _____ Middle: _____
Prefix: _____ Suffix: _____ Date of Birth: _____ SS#: _____
Relationship to Patient: _____ Martial Status: _____ Primary Language: _____
Address: Line1: _____ Line2: _____
Zip: _____ City: _____ State: _____ County:_____

Phone: Home: _____ Work: _____ Cell: _____
Email: _____

Employer: Name: _____
Address: _____

***Emergency Contact**: _____ _____ _____
Name Daytime Contact # Relationship to Patient
Patient's Name: _____

INSURANCE INFORMATION

Responsible Party (Mother/Father/Guardian): _____

Primary Insurance
Carrier/Insurance Co.: _____
Group # : _____
Member ID#: _____
Insured Name: _____
Relationship to patient _____

Secondary Insurance (if applicable)
Carrier/Insurance Co.: _____
Group #: _____
Member ID#: _____
Insured Name: _____
Relationship to patient: _____

I hereby assign payment to Kids First Pediatric Group, LLC (KFPG) for all medical benefits, otherwise payable to under terms of my insurance contract as payment towards the total charges for professional services rendered. I understand that I am responsible for charges not covered under this assignment. Payment is expected in full prior to services being rendered. The undersigned agrees that they are jointly and separately liable for the paym of any services, medications, or other items provided to the patient. The filing of insurance by KFPG is a courtesy and shall not act to amend or void your obligation to pay the balance due. All obligations are due and payable upon receipt of statement. If any amount due shall require collections by or with the assistance of any attorney, the undersigned shall be additionally responsible for all attorney's fees, court cost, or other expenses of collection, not more than 30% of the balance at the time of placement for collections and will be added to the patient balance. I hereby authorize Kids First Pediatric Group, LLC and/or it's staff to release medical information to insurance companies concerning the patient's illness and treatments.

All fees for laboratory studies that cannot be performed on-site and require being sent to an outside reference lab are the sole responsibility of the parent and/or guarantor.

_____ _____
Patient or Guarantor's Signature Date

_____
Print Name