WAVERLY HEALTH CENTER

Pediatric Patient Demographics
(Ages 17 and Under)

Date: _____ Family Doctor: _____

Patient's Name: _____
First Middle initial Last

Birth Date: _____ Social Security #: _____

Physical Address: _____
Street City State County Zip

Mailing Address: ☐ Same as above _____
Street/P.O. Box City State County Zip

Home Phone: _____ Cell Phone: _____

Other Demographic Information

Birth Sex: ☐ Male ☐ Female **Preferred Language**: _____

Sexual Orientation: ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Unknown ☐ Decline to Answer

Gender Identity: ☐ Male ☐ Female ☐ Female-to-Male/Transgender Male
☐ Male-to-Female/Transgender Female ☐ Genderqueer ☐ Decline to Specify

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hawaiian/Pacific Islander
☐ American Indian/Alaska Native ☐ Decline to Answer ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Answer

Preferred Pharmacy: _____

Parent Information

Father's Name: _____ Date of Birth: _____
Marital Status: _____ Home Phone: _____
Address: ☐ Same as patient _____ Email Address: _____
Mother's Name: _____ Date of Birth: _____
Marital Status: _____ Home Phone: _____
Address: ☐ Same as patient _____ Email Address: _____

Insurance

Card Holder: _____ Card Holder Date of Birth: _____
Insurance Company: _____ Member Number: _____

Person other than Parents to Contact in an Emergency

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

I certify that the above information is accurate.

Signature: _____ Date: _____