Child/Adolescent Demographic Form

Patient Legal Birth Name:	**Date of Birth**:
Chosen Name:	**Social Security #:**
Gender: Male Female Transgender- (male to female) Transgender- (female to male) Non-binary Chose not to disclose **Pronouns:**	
Address:	
Primary Phone Number:	**Alternative Number**:
Employer:	**Occupation:**

Parents Information

Mothers Name:	**Date of Birth:**
Address:	
Primary Phone Number:	**Alternative Number:**
Employer:	**Occupation:**
Fathers Name:	**Date of Birth:**
Address:	
Primary Phone Number:	**Alternative Number:**
Employer:	**Occupation:**

Emergency Contact Information

Emergency Contact:	**Relationship:**
Home Phone Number:	**Cell Phone Number:**

Reason for visit

Insurance Information

Primary Insurance:	**Member Identification #:**
Marital Status: Single married divorced separated widow domestic partner	**Group Number:**
Subscriber First Name:	**Subscriber Last Name:**
Subscriber Employer:	**Subscriber Date of Birth:**
Relationship to Insured:	**Subscriber Social Security #:**

Secondary Insurance

Secondary Insurance:	**Member Identification #**
Marital Status: Single Married Divorced Separated Widow Domestic Partnership	**Group Number:**
Subscriber First Name:	**Subscriber Last Name:**
Subscriber Employer:	**Subscriber Date of Birth:**
Relationship to Insured:	**Subscriber Social Security #**:

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