916 South 3rd Street
Mt. Vernon, WA 98273-4324
Voice: (360) 336-5658
Fax: (360) 336-5655

Baby and Pediatric Demographics

Date: __________

Last Name: ______________________________ First Name: ________________________ MI: _________

Preferred Name (if applicable): ________________ Date of Birth: ________________ Sex: _________

Social Security #: ___________________________

Preferred Pharmacy (please select one): ________________________ **City:** ____________________

Race (check one): ____White ____American Indian/Alaska Native ____Asian
____Black/African American ___Nat Hawaiian/Pacific Is ____Other _____Declined

Ethnicity (check one): ____ Hispanic/Latino _____Not Hispanic or Latino ______Declined

Primary Language (check): ____English ____Other: _______________ Religion: _________________

Mother's Name: _____________________________________ ***DOB:*** ________________

Father's Name: ______________________________________ ***DOB:*** ________________

Child lives with: □ ***both parents*** □ ***mother*** □ ***father*** □ ***other*** ______________________

Who will be the guarantor for this account? ________________________ ***Date of Birth:*** ______________

Address (if different from patient) ____________________________________ ***Phone:*** ________________

Mailing Address ____

City: ____________________________________ State: __________ Zip code: ____________________

Street Address: ____ Apartment #: _________

City: ____________________________________ State: __________ Zip code: ____________________

Home Phone: ____________________ Cell Phone: _________________ Work Phone: ________________

Email (required for patient portal): ___________________________________

Preferred Communications: ____Cell phone ____Home phone ____Work phone ____Mail ____Email ___
____Text

Emergency Contact: ______________________________ **Contact's Phone #:** _____________________

See Other Side

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Primary care provider (PCP)? Dr.________________________________ Phone #:____________________

How did you hear about our clinic? ___________________________________

Primary Insurance Company: ____

ID Number: _____________________________________ Group/Policy Number: _____________________

Name of policy holder: _______________________ **If policy holder is the same, check here:** □

Policy holder's DOB: _______________________ Policy holder's SSN: _____________________________

Relationship to policy holder: □ spouse □ child □ other _________________________

Secondary Insurance Company: ____

ID Number: _______________________________ Group/Policy Number: ___________________________

Name of policy holder: ______________________________ DOB: _____________ SSN: ______________

Relationship to policy holder: □ spouse □ child □ other _______________________

See Other Side