[LOGO HERE]

New Patient Demographics Form

Patient Information

Last Name: [_____] First Name: [_____] Middle Name: [_____]

Address: [_____]

City: [_____] State: [_____] Zip: [_____]

DOB: [_____] SSN: [_____-_____-_____] Gender: []Male []Female []Preferred[_____]

Sibling: [_____] DOB: [_____] Gender: []Male []Female

Sibling: [_____] DOB: [_____] Gender: []Male []Female

Sibling: [_____] DOB: [_____] Gender: []Male []Female

Sibling: [_____] DOB: [_____] Gender: []Male []Female

Primary Guarantor Information & Insurance

Last Name: [_____] First Name: [_____] DOB: [_____]
Address: [_____]

City: [_____] State: [_____] Zip: [_____]

SSN: [_____-_____-_____] Gender: []Male []Female Relationship to Patient: [_____]
Employment Status: [_____] Occupation: [_____]

Employer: [_____]

Home Phone: [_____] Work Phone: [_____] Mobile: [_____]

Email: [_____]

Insurance Company: [_____] Subscriber's I.D. #: [_____] Group #: [_____]
Insurance Company Address: [_____] City: [_____]

State: [_____] Zip: [_____] Insurance Company Phone Number: [_____]

Parent / Guardian Information

Parent / Guardian #1: (if different than Guarantor Information)

Last Name: [_____] First Name: [_____] DOB: [_____]
Address: [_____] City: [_____] State: [_____]
Zip: [_____] SSN: [_____-_____-_____] Gender: []Male []Female

Relationship to Patient: [_____] Home Phone: [_____]

Work Phone: [_____] Mobile: [_____] Email: [_____]

Marital Status: [_____] Occupation: [_____]

Employer: [_____]

Parent / Guardian #2: (if different than Guarantor Information)

Last Name: [_____] First Name: [_____] DOB: [_____]
Address: [_____] City: [_____] State: [_____]
Zip: [_____] SSN: [_____-_____-_____] Gender: []Male []Female

Relationship to Patient: [_____] Home Phone: [_____]

Work Phone: [_____] Mobile: [_____] Email: [_____]

Marital Status: [_____] Occupation: [_____]

Employer: [_____]

Emergency Contact

Please list someone other than Parent / Guardian:

Last Name: [_____] First Name: [_____]

Relationship to Patient: [_____] Home Phone: [_____]

Work Phone:[_____] Mobile: [_____] Email: [_____]

Assignment & Release

Please review and sign authorizations below to expedite claim processing. If you feel that a claim has been denied in error, it is your responsibility to contact the insurance company. Questions regarding your account may be directed to our Practice Manager, Jake Masterman, at 813-563-6070.

I hereby authorize payment of medical benefits directly to Sandhill Pediatrics PA. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: [_____] Date: [_____]