Port City Pediatrics

Sibling/Additional Child Demographic Update

PLEASE COMPLETE ALL FIELDS PERTAINING TO THE PATIENT. THIS INFORMATION WILL HELP US BETTER SERVE OUR PATIENTS AND HELP IN THE BILLING PROCESS. THIS FORM MUST BE FILLED OUT FOR EACH SIBLING/ADDITIONAL CHILD, SEE FRONT DESK RECEPTIONIST FOR MORE FORMS.

PATIENT INFORMATION

Patient's Full Name: _____
Last First Middle

Date of Birth: ___/___/_____ ☐ Male ☐ Female Child's SSN: _____

WHO HAS GUARDIANSHIP OF THIS CHILD? ☐ Mother ☐ Father ☐ Both ☐ Foster ☐ Other

If other, please give name: _____ Relation to child: _____

Mother's Name: _____ Date of Birth: __/__/____ Employer: _____

Address: _____
Street Number and Name City State Zip Code

Father's Name: _____ Date of Birth: __/__/____ Employer: _____

Address: _____
Street Number and Name City State Zip Code

PARENTAL STATUS

☐ Married ☐ Single ☐ Widowed ☐ Divorced

DIVORCED PARENTS ONLY

A COPY OF YOUR DIVORCE DECREE IS REQUIRED FOR YOUR CHILD'S CHART THAT STATES THE FOLLOWING.

- Which parent has physical custody, one or both
- Which parent is financially responsible for medical care
- Whose insurance is primary and whose insurance is secondary

PLEASE BRING THIS DOCUMENTATION TO YOUR NEXT SCHEDULED APPOINTMENT.

_____ _____
Printed Patient Name Patient Email

_____ _____/_____/_____
Signature of Patient Today's date