Camkids Pediatrics P.C.
117-06 225th Street ♦ Cambria Heights ♦ NY 11411 ♦ Tel# (718) 712-8511

PATIENT DEMOGRAPHICS

Today's Date: ____ ____ ____
mm dd yy

PATIENT INFORMATION						
NAME (Last Name, First Name)			**Sex**		**Date of Birth**	
			M	**F**	mm dd yy	
ADDRESS (Street, City, State, Zip)	**Race**	**Ethnicity**			**Language**	
		Hispanic ☐				
		Non-Hispanic ☐				
HOME PHONE #:		**CELL PHONE #:**				

GUARDIAN INFORMATION	
MOTHER	**FATHER**
NAME	**NAME**
ADDRESS (if different)	**ADDRESS** (if different)
EMPLOYER	**EMPLOYER**
WORK PHONE #	**WORK PHONE #**

INSURANCE INFORMATION	
PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE NAME	**INSURANCE NAME**
POLICY ID #	**POLICY ID #**
POLICY HOLDER'S NAME	**POLICY HOLDER'S NAME**
POLICY HOLDER'S SS #	**POLICY HOLDER'S SS #**
POLICY HOLDER'S DOB	**POLICY HOLDER'S DOB**

OTHER INFORMATION		
NAME OF NEAREST RELATIVE (not living with you)	**RELATIVE'S ADDRESS**	**RELATIVE'S PHONE #**
PARENT'S E-MAIL ADDRESS (not for marketing purposes)	**Who should we thank for this Referral?**	
PHARMACY NAME & ADDRESS:		