ALPHA PEDIATRICS,PA

502 Madison Oak Suite # 245
San Antonio, TX 78258
Phone (210) 404-2532
Fax (210) 404-2539

Patient Demographic Form

Be sure to download and save this document to your computer. This form can be filled out on your computer and emailed to alphapedi01@gmail.com or print the form out and bring it to the office filled out. Thank You!

Patient's Information:

Last Name, First Name: _____ Middle Name: _____ Date of Birth: _____
Social Security #: _____ Sex: ☐ M ☐ F

Patient's Home Address:

Home Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____

Race:

- ☐ Decline
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other _____

Ethnicity:

- ☐ Decline
- ☐ Hispanic
- ☐ Latino
- ☐ Not Hispanic
- ☐ Not Latino
- ☐ Other _____

Preferred Language:

- ☐ Decline
- ☐ English
- ☐ Spanish
- ☐ Arabic
- ☐ Other _____

Guarantor Information:

Last Name, First Name: _____ Middle Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Social Security #: _____ Sex: ☐ M ☐ F
Marital Status: _____ Name of Employer: _____ Occupation: _____
Best Phone Number to Contact you or Leave a Message: _____

Parent or Guarantor's Information: *(If same as above please leave blank)*

Mother's Name: _____ Date of Birth: _____
Social Security Number: _____ Alternative Phone Number: _____
Father's Name: _____ Date of Birth: _____
Social Security Number: _____ Alternative Phone Number: _____

Pharmacy Information:

Pharmacy Name: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip Code : _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____
Policy Number: _____ Policy Number: _____
Group Number: _____ Group Number: _____
Insured Name: _____ Insured Name: _____
Relationship to Patient: _____ Relationship to Patient: _____

Emergency Contact:

Name: _____ Address: _____ City: _____ State: _____
Zip: _____ Contact Number: _____ Relation to Patient: _____

Patient's Referral Information:

Name: _____ Phone: _____

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to PRACTICE NAME, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign: _____ Date: _____