Bloom Pediatrics
Where Good Health Grows

PATIENT DEMOGRAPHICS

Patient Information

Patient's First Name_____ Middle_____ Last_____

Nickname_____Male___Female___ Birth Date____/____/____Primary Physician_____

Parent 1 Name_____Date of Birth_____/_____/_____

Parent 2 Name_____Date of Birth_____/_____/_____

Patient lives with: Name(s)_____ Relationship(s)_____

Patient lives at_____
Street Address City State Zip Code

Bills are sent to_____
Name Street Address City State Zip Code

Email Address_____ Owner of Email Address_____

Primary Phone Number_____ Owner of Phone Number_____

2nd Phone Number_____ Owner of Phone Number_____

Emergency Contact_____

Relationship to Patient_____ Phone Number_____

☐ I authorize Bloom Pediatrics to leave a detailed message on my voicemail.
☐ I **do not** authorize Bloom Pediatrics to leave a detailed message on my voicemail.
☐ I give permission for Bloom Pediatrics to text me a message to call back.

Ethnicity: Hispanic/Latino_____ Not Hispanic/Latino_____ Prefer not to answer_____

Race: White_____ American Indian/Alaskan Native_____ Asian_____ Black/African American_____ Native HI/Pacific IS_____ Prefer not to answer_____

Preferred Language_____ Other Language_____

Do you need an interpreter? Yes_____ No_____ What Language?_____

Insurance Information

Primary Insurance Name_____ Copay_____

ID Number_____ Group Number_____

Subscriber's Name_____ Birth Date_____ Start Date_____

Employer_____

Secondary Insurance Name_____ Copay_____

ID Number_____ Group Number_____

Subscriber's Name_____ Birth Date_____ Start Date_____

Employer_____

Insurance Authorization and Assignment (Please read and Sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my visits to my insurance carrier. **I understand that I am responsible for my entire bill unless this form is complete.**

Parent/Guardian/Patient Signature_____Date_____