Pure Joy PEDIATRICS
15405 SW 116th Ave, Suite 116 | King City, OR 97224
Phone: 503-420-8667| Fax: 971-512-3246 | www.PureJoyPediatrics.com

PATIENT DEMOGRAPHIC FORM (new patients only)

Patient Information

Name (Last, First, MI)			Date
Street Address	City	State	Zip
Home Phone ☐Preferred	Work Phone ☐Preferred	Cell Phone ☐Preferred	
SSN	Date of Birth	Gender ☐Female ☐Male	Marital Status ☐ N/A (Child) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Religion (optional)	Ethnicity (optional)	E-mail address	

Responsible Party (Guarantor Information)

Is patient responsible party? ☐ Yes ☐ No			
Name (Last, First, MI)	Relationship to patient		
Street Address	City	State	Zip
Home Phone ☐Preferred	Work Phone ☐Preferred	Cell Phone ☐Preferred	
Occupation	Employer	Date of Birth	

Emergency Contact

Name	Relationship to Patient	
Home Phone ☐Preferred	Work Phone ☐Preferred	Cell Phone ☐Preferred

Pharmacy Information

Pharmacy Name	Pharmacy Phone (if known)
Pharmacy Address	Pharmacy Fax (if known)

Insurance Info

Primary Insurance Company	Policy #	Group #		
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐Other _____	Name of Subscriber (if other than patient)			
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone
Secondary Insurance Company	Policy #	Group #		
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐Child ☐ Other _____	Name of Subscriber (if other than patient)			
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Parent Signature (if patient is under age 18): _____ Date: _____/_____/_____