Post Falls Family Medicine, P.A.

Child(ren) Demographic Information

Today's Date: ________________ How did you hear about us? ____________________________

Child's full Name: ____ **Date of Birth**: ______________ SS#: ________________ M or F

Race (government census):

American Indian or Alaskan Native______ Asian______ Black or African American______ White______ Native Hawaiian or Other Pacific Islander______

Declined to Specify ______

Ethnicity:

Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______

Language Preference: ______________

Additional children: (if any)

Child's full Name: ____ **Date of Birth**: ______________ SS#: ________________ M or F

Race (government census):

American Indian or Alaskan Native______ Asian______ Black or African American______ White______ Native Hawaiian or Other Pacific Islander______

Declined to Specify ______

Ethnicity:

Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______

Language Preference: ______________

Child's full Name: ____ **Date of Birth**: ______________ SS#: ________________ M or F

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American Indian or Alaskan Native______ Asian______ Black or African American______ White______ Native Hawaiian or Other Pacific Islander______

Declined to Specify ______

Ethnicity:

Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______

Language Preference: ______________

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Declined to Specify ______

Ethnicity:

Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______

Language Preference: ______________

Do the child/children live with both parents? **Y/N** If not, who is the legal guardian? ____________________________________

Child's Physical Address: ___________________________________City: __________________ State: _____ Zip: ____________

Child's Mailing Address: _____________________________________ City: ____________________ State: _____ Zip: _________

Best contact phone #: ______________________ whose phone is this _________________ Alt. phone: __________________

Mother's Information

Mother's full name: ______________________________ Phone/Cell: ___________________________ SS#: _______________

Address: ____ City: _________________________ State: ______ Zip: __________

Father's Information

Father's full name: ______________________________ Phone/Cell: ___________________________ SS#: _______________

Address (if different from Mother's): ___________________________________ City: ________________ State: _____ Zip: __________

Person Responsible for the account

(No absent parent billing)

Please note, just because a parent carries the child under their insurance plan, does not mean they are responsible for the balance due after insurance has processed. Please indicate who will be responsible for the account.

☐ Mother ☐ Father ☐ Other: ______________________________