**CareSouth Carolina, Inc. Pediatric Patient Demographic Sheet** MR-Demographic Form-2013-04-06

Today's Date____/____/____ Chart#:____ Account#:____

## Patient Information:

Name:____ (Last) (First) (M.I) Birthdate:____/____/____ Sex: □ Male □ Female

Address:____ (PO Box or Street) (City) (State) (Zip) Home Phone: (____)____

SS#:____-____-____ **VERY IMPORTANT** (In case of emergency) Cell/Other Phone: (____)____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other ____ |Ethnicity □ Hispanic □Not Hispanic

Housing: Are you currently homeless? □ Yes □ No Do you have a regular place to stay at night? □ Yes □ No Do you sleep in a shelter, halfway house or other type of temporary or transitional public shelter/housing? □ Yes □ No

Race: □ Black/African American □ White/Caucasian □ Native American/Alaska Native/American Indian □ Asian □ Native Hawaiian □ Other Pacific Islander □ More than One Race □ Other____

Primary Language: □ English □ Spanish □ Other____
Agricultural Work Status: □ Non-Agricultural □ Migrant □ Seasonal □ Employed year round

Mother's Name:____ Father's Name:____

Guardians Name:____ Other:____

Primary Phone :(____)____ Alternative Phone: (____)____

## Alternate Pediatric Consent (leave blank if non-applicable):

I give permission for CareSouth Carolina to provide medical treatment to my child when brought in by the persons below. This authorizes CareSouth Carolina to give information on the diagnosis of that day's visit (along with labs or X-rays) and allows us to inquire of the financial obligations as well.

***Please list names of person(s) allowed to bring your child/ren in below:***

| NAME: | RELATIONSHIP: | TELEPHONE#: |
|---|---|---|
| | | |
| | | |
| | | |

**Primary Pharmacy Name:**____ Location/City:____

**Secondary Pharmacy Name:**____ Location/City:____

## Insurance Information:

Primary Insured's Name:____ Relationship:____ Insured's SS#:____-____-____

Birthdate:____/____/____ Insured's Address:____ Employer:____

Insurance Company Name:____ Insurance Phone Number: (____)____

Policy#____ Group#____ Copay: $____

2ndary Insured's Name:____ Relationship:____ Insured's SS#:____-____-____

Birthdate:____/____/____ Insured's Address:____ Employer:____

Insurance Company Name:____ Insurance Phone Number: (____)____

Policy#____ Group#____ Copay: $____

**Sliding Fee Scale Information:** _____ **%** **Category:**____ **Date:**____/____/____

**AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT & RELEASE OF MEDICAL INFORMATION FOR CLAIMS PROCESSING / FINANICAL RESPONSIBITY**

I hereby authorize CareSouth Carolina, Inc. staff (and whomever they delegate) to provide medical, emergency and in-patient care of such treatment that may include/but is not limited to health screening, diagnoses, medical treatment, social services, and/or mental health & drug & alcohol screening, assessment, diagnoses, and treatment as is found necessary. I also authorize the release of any medical information necessary to process claims and promote continuity of care with other healthcare and enabling services. I authorize payment to be made to CareSouth Carolina, Inc.

How did you hear about us? □ Newspaper □ Television (TV) □ Friend □ Family Member □ Health Fair □ Outreach Worker □ Referral ____ □ Other ____

Patient / Guardian Signature:____ Date:____/____/____

Witnessed By:____ Date:____/____/____

____ ____ ____

Reviewed By: **(Should be reviewed by front office personnel at least every 6 months)**: