Delaware Pediatric Associates, LLP
2550 Delaware Ave.
Buffalo, NY 14216
(716) 884-0230

Patient Demographic Registration Form

Please PRINT

MRN **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Preferred Name**

Date of Birth **Email Address** **Gender** ☐ Male ☐ Female ☐ Other: _____

Race:
☐ Asian/Asian Indian
☐ Hawaiian/Pacific Islander
☐ Black/African American
☐ Black/African American
☐ Caucasian
☐ Native American/Alaskan Native
☐Multi-Race
☐Other:
☐Decline to Answer
☐Unknown

Language: Other than English _____

Ethnicity (optional):
☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Do you need an Interpreter? ☐ Yes ☐ No

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

HOW DID YOU HEAR ABOUT US?

How did you hear about us? ☐ Billboard ☐ Employer ☐ Family/Friend ☐ Insurance ☐ Other Physician ☐ Website ☐ Other: _____

Referring Physician (if applicable)

PARENT/RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self ☐ Parent ☐ Other

Last Name **First Name** **Middle Initial**

Maiden Name (birth mom)

Date of Birth **Email**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

SECOND PARENT/EMERGENCY CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

PRIMARY INSURANCE INFORMATION

Insurance Holder Last Name (Subscriber)	First Name		Relationship to Patient		Date of Birth
Address (if different)	**Apt #**	**City**	**State**	**Zip Code**	**Phone Number**
Health Plan Name	**Insurance ID #**		**Insurance Group #:**		

SECONDARY INSURANCE INFORMATION

Insurance Holder Name (Subscriber)	First Name		Relationship to Patient		Date of Birth
Address	**Apt #**	**City**	**State**	**Zip Code**	**Phone Number**
Health Plan Name	**Insurance ID #**		**Insurance Group #**		

PRIMARY PHARMACY

Primary Pharmacy				
Address	**City**	**State**	**Zip Code**	**Phone Number**

SIBLINGS

Siblings Name	Age	Siblings Names	Age

OFFICE USE ONLY

Information reviewed by: _____

Referred By: _____

- **Please bring your insurance card (s) and applicable copay (s) to your child's appointment. Thank you!**