



## Mobile Health Team Kids Demographics Form

Patient's name full name: \_\_\_\_\_ *Male or Female* D.O.B: \_\_\_\_\_

Today's date \_\_\_\_\_ Referred by: \_\_\_\_\_

Child's Primary Address: \_\_\_\_\_  
Street City State Zip

(If another sibling is also being seen by our clinic, please provide Name(s) and DOB(s) and complete only one of these forms): \_\_\_\_\_

### **RESPONSIBLE INSURANCE PARTY INFORMATION (PARENT 1)**

Primary Insured's Name \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

**PARENT 2 - CONTACT INFORMATION** Parent 2's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
Street City State Zip

Home Phone (if different from PARENT 1): \_\_\_\_\_ Cell: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**PARENTS' MARITAL STATUS** (please circle one) *Married* *Single* *Divorced* *Widowed*

### **PRIMARY INSURANCE INFORMATION**

Insurance company: \_\_\_\_\_ Employer Group Name as Listed on Insurance Card \_\_\_\_\_

Policy/ID/Subscriber Number: \_\_\_\_\_ Group Number \_\_\_\_\_

Primary Insured Name as Listed on Insurance Card \_\_\_\_\_

### **SECONDARY INSURANCE INFORMATION**

Insurance company: \_\_\_\_\_

Policy/ID/Subscriber Number: \_\_\_\_\_ Group Number \_\_\_\_\_

Primary Insured Name as Listed on Insurance Card \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONTACT PREFERENCES:**

Preferred Phone for contact: \_\_\_\_\_ which is (circle):

Home          Mom's Cell          Dad's Cell          Other \_\_\_\_\_

Preferred Email Address for your family \_\_\_\_\_

May we send you appointment reminders by:     Email?           Mobile Text?

If we are unable to reach you by phone, may we leave a message?     No

Yes, but only messages with appointment times or callback information

Yes, my preferred phone is secure. You may leave detailed health information

**THERE ARE MANY WAYS WE CAN PROVIDE YOU WITH SUPPORT! WOULD YOU LIKE FURTHER INFORMATION FROM US ON:**

Patient Portal for viewing your medical records and securely emailing/messaging us

Tele-health (Video Medical Appointments)           In-Person Classes

Online Classes           Health Apps for Devices

Email Newsletter \_\_\_\_\_

WEBSITE: [MobileHealthTeam.com](http://MobileHealthTeam.com) • PHONE: 844.547.4343 (844.LIPID.HELP) • FAX: 844.885.9574