# Patient Profile

## Patient Information

Name: _____ Gender: M / F

Name of hospital where your child was born _____

Date of Birth: _____ **Social Security #:** _____

**Primary Language:** __ English __ Spanish __ Other _____

**Race:** __ White __ African American __ Asian __ Multiracial

**Religion:** __ Christian __ Roman Catholic __ Baptist __ Refuse to Answer __ Other _____

**Ethnic Group:** __ Not Hispanic or Latino __ Hispanic or Latino __ Unknown

**Smoking Status:** __ Never Smoked __Former Smoker __ Current Smoker

## Parent/Guardian Information

| FATHER/OTHER | MOTHER/OTHER |
|---|---|
| Name: | Name: |
| Address: | Address: |
| City/ST/Zip: | City/ST/Zip: |
| Home Phone: | Home Phone: |
| Cell Phone: | Cell Phone: |
| Social Security No.: | Social Security No.: |
| Date of Birth: | Date of Birth: |
| Employer: | Employer: |
| Email Address: | Email Address: |

## Insurance Information

- Please Note that you will be asked for your insurance card at every visit

Insurance Company _____ Insured ID # _____

Address _____ Policy Group # _____

Do you have secondary Insurance? Yes ___ No ___ If Yes, Insured Name: _____

Ins. Carrier Name: _____ ID# _____ Grp: _____