1473 N. Lee Trevino
El Paso, TX, 79936
Phone: 915-280-9267
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Demographic Form

Patient information (child)

First name: _____
Last name: _____
Date of Birth: _____
Sex: ☐M ☐F
Child's relationship to responsible party:
_____

Birth Hospital: _____
Is this your first visit to our office: ☐Y ☐N
Sibling information:
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Parent Information

Parent #1
First name: _____
Last name: _____
Sex: ☐ M ☐ F
Address (if different from above): _____
Social security #: _____
Date of birth: _____
Relationship to patient: _____
Employer: _____
Phone (home/cell): _____
Email: _____

Parent #2
First name: _____
Last name: _____
Sex: ☐ M ☐ F
Address (if different from above): _____
Social security #: _____
Date of birth: _____
Relationship to patient: _____
Employer: _____
Phone (home/cell): _____
Email: _____

Insurance Information:

Primary Insurance
Policyholder's name: _____
Policyholder's DOB: _____
Relationship to patient: _____
Insurance Name: _____
SS#: _____
Employer: _____
Group Name or #: _____
Insured's ID #: _____
Address of policy holder: _____

Secondary Insurance
Policyholder's name: _____
Policyholder's DOB: _____
Relationship to patient: _____
Insurance Name: _____
SS#: _____
Employer: _____
Group Name or #: _____
Insured's ID #: _____
Address of policy holder: _____

Emergency Contact/Consent for another caregiver:

I give the following person/persons permission to obtain care for my child at Desert Bloom Pediatrics in my absence. I also give this person/persons permission to contact Desert Bloom Pediatrics to obtain any medical advice, medical information/records, and/or insurance/billing information necessary for said child.

Name	Phone number	Relationship to child

I attest that all of the above information is correct and acknowledge that it is my responsibility to let Desert Bloom Pediatrics know as soon as possible if any of my information changes.

Signature: _____ Date: _____