Adena Family Medicine-Ironmen Clinic

Patient Demographic Information

Student Name (Last, First, M.I.) _____ **DOB**_____

School Attended:_____**Grade Level**_____

Home Street Address_____**City**_____

State_____ **Zip** _____ **Email**_____

Home Ph._____ **Cell Ph.**_____ **Work Ph.**_____

Would you like to be signed up for the patient portal to access your medical records electronically? ☐ **Yes** ☐ **No**

What is your preferred method of contact? ☐ **Phone** ☐**Cell Ph.** ☐ **Pt. Portal** ☐ **Text**

Sex: ☐ **M** ☐ **F** **Race**_____ **Ethnicity**_____ **Language**_____

Mother's Name _____

Father's Name _____

Legal Guardian's Name (if applicable)_____

**Please attach a copy of proof of legal guardianship if it hasn't been previously provided to the clinic.*

Primary Care Provider/Pediatrician (name & Clinic) _____

Emergency Contact: _____

Emergency Contact Address_____

Emergency Contact Phone_____ **Relationship**_____

Insurance Name_____ **Subscriber Number**_____

Group Number_____ **Group Name**_____

Insured Name_____ **Relationship to Patient**_____

Local Pharmacy_____

Mail Order Pharmacy_____

_____ _____

Signature of Person Completing this Form **Date**

(Should be completed by parent/legal guardian)