

Apex Pediatrics Fuquay Varina Pediatrics Patient Demographic Sheet

Patient Name:		L)OB:/		PCC#:		
Children (Full Legal Nam	es/Nickname) (Please check	the box next to th	ne children that a	ire here fo	r an appointment tod	ay)	
□ Name		/	Sex	(DOB		
					DOB		
	Name*:						
Name of Legal Guar					Optional		
Street Address:			List b	elow any ad	Iditional contacts for the p	patient:	
City, State & Zip code:			Contact Name:				
Preferred Phone#:			Phon	e#:			
Cell Phone#:		Relationship:					
Work Phone#:			Cont	act Name:			
Home Phone:		Phone	Phone #:				
Email:			Relat	ionship:			
	do not have your insura	ance card pleas	se provide the	followin	ng information:	٦	
	Name of Insurance and Ph# Policy ID#					-	
Group #						†	
Employer						1	
Signature of Patient	:hat I am financially res			ther or	not paid by insura		
Print Name:							
	* p	New Patients	Only*				
Which racial category	does the patient most clos	ely identify with	?				
African American	☐ American Indian/ Alask		□ Asian		□ Caucasion		
☐ Hispanic ☐ Native Hawaiian/ Other Pacific Islander		☐ More Than (One Race	Other:	(please speci		
Ethnicity: What is the patient's ethnicity?			☐ Hispanic or I		□ Not Hispanic or L	atino	
What is the patient/family's language of preference?			English	Spanish	Other:	(nlease spec	