Children's of Alabama

PATIENT DEMOGRAPHIC SHEET / REGISTRATION FORM

PATIENT: NAME _____ PREFERS TO BE CALLED _____
DATE OF BIRTH _____ SEX ASSIGNED AT BIRTH _____ LEGAL SEX _____

ADDRESS
_____
CITY _____
STATE _____ ZIP _____ COUNTY _____

PHONE NUMBERS
HOME PHONE _____
MOBILE PHONE _____

EMAIL ADDRESS _____

MARITAL STATUS _____ NEEDS INTERPRETER? _____ PREFERRED LANGUAGE_____

ENGLISH FLUENCY _____ WRITTEN LANGUAGE _____ RELIGION _____

RACE (choose all that apply)

- ○ AMERICAN INDIAN OR ALASKA NATIVE
- ○ ASIAN
- ○ BLACK/AFRICAN AMERICAN
- ○ HISPANIC/LATINO/A OR SPANISH ORIGIN
- ○ MIDDLE EASTERN OR NORTH AFRICAN
- ○ NATIVE HAWAIIAN OR PACIFIC ISLANDER
- ○ WHITE
- ○ OTHER, RACE NOT LISTED
- ○ DECLINE TO ANSWER
- ○ UNKNOWN

ETHNICITY

- ○ DECLINE TO ANSWER
- ○ HISPANIC OR LANTINO/A OR SPANISH ORIGIN
- ○ NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN
- ○ UNKNOWN

PARENT/GUARDIAN: NAME: _____DATE OF BIRTH _____
ADDRESS (SAME AS PATIENT? YES/NO)
_____
CITY _____
STATE _____ ZIP _____ COUNTY _____
EMAIL ADDRESS _____
OCCUPATION _____

PHONE NUMBERS:
HOME PHONE _____
MOBILE PHONE _____

PARENT/GUARDIAN: NAME: _____DATE OF BIRTH _____
ADDRESS (SAME AS PATIENT? YES/NO)
_____
CITY _____
STATE _____ ZIP _____ COUNTY _____
EMAIL ADDRESS _____
OCCUPATION _____

PHONE NUMBERS:
HOME PHONE _____
MOBILE PHONE _____

EMERGENCY CONTACT: NAME: _____
ADDRESS:
_____
CITY _____
STATE _____ ZIP _____ COUNTY _____
EMAIL ADDRESS _____

PHONE NUMBERS:
HOME PHONE _____
MOBILE PHONE _____

INSURANCE INFORMATION:
PRIMARY INSURANCE _____ POLICY HOLDER NAME _____
POLICY # _____ GROUP # _____ EFFECTIVE DATE _____
POLICY HOLDER DATE OF BIRTH _____
SECONDARY INSURANCE _____ POLICY HOLDER NAME _____
POLICY # _____ GROUP # _____ EFFECTIVE DATE _____
POLICY HOLDER DATE OF BIRTH _____
PREFERRED PRIMARY PROVIDER _____
PREFERRED PHARMACY NAME _____PHARMACY LOCATION _____
PHARMACY PHONE _____
MAIL ORDER PHARMACY NAME/ADDRESS/PHONE _____