Lakeshore Health Partners
A Holland Hospital Physician Office

Pediatric Demographic Questionnaire

Date: _____

Patient Information:

Name: _____/_____/_____ Gender: 0 Male 0 Female
(Last) (First) (M.I.)

Date of birth: ____/_____/_____ Age: _____ Social Security#: _____

Address: _____
(Street) (City) (Zip Code)

Phone Number: (_____)_____ Other Phone: (_____)_____

Father's Name: _____ Date of birth: _____ / ____ / _____

Father's Address: _____
(Street) (City) (Zip Code)

Father's Phone Number: (_____)_____

Mother's Name: _____ Date of birth: _____ / ____ / _____

Mother's Address: _____
(Street) (City) (Zip Code)

Mother's Phone Number: (_____)_____

Insurance Information:

Primary Insurance Carrier: _____

Policy or Contract Number: _____

Name of Subscriber on the insurance plan: _____

Date of birth of subscriber: ____ / ____ / _____ Social Security #: _____

Employer: _____ Group Number: _____

Secondary Insurance carrier: _____

Policy or Contract Number: _____

Name of Subscriber on the insurance plan: _____

Date of birth of subscriber: ____ / ____ / _____ Social Security #: _____

Employer: _____ Group Number: _____

Who can we thank for referring you to our office? _____