

# La Altura Pediatrics

## Patient Demographic Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female Soc. Security No. : \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Home Phone:( ) \_\_\_\_\_ Alt. Phone:( ) \_\_\_\_\_

Parent/Guardians: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

## Primary Insurance

Insurance Co: \_\_\_\_\_

Any other Insurance? \_\_\_\_\_ If yes, Insurance Co: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_

Insured Employed by: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

## Family Information

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Other Siblings: \_\_\_\_\_ M \_\_\_ F \_\_\_  
Name DOB

\_\_\_\_\_ M \_\_\_ F \_\_\_  
Name DOB

\_\_\_\_\_ M \_\_\_ F \_\_\_  
Name DOB