PONDEROSA PEDIATRICS

6512 S. McCarran Blvd, Suite D
Reno, NV 89509
Phone: 775-900-9987
Fax: 775-900-9954

Demographics Update

Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____
Patient Name: _____ D.O.B.: _____

Please complete all items for each **biological** parent or **legal** guardian.
****Stepparents are not included here unless they are legal guardians****

Parent Name (Last, First, MI):_____
Street Address: _____D.O.B.: _____
City, State & Zip: _____Home Phone:_____
Cell Phone: _____ Work Phone: _____
E-mail: _____
Employer: _____ Occupation: _____
Relationship to Patient: _____ Lives with patient: _____

Parent Name (Last, First, MI):_____
Street Address: _____D.O.B.: _____
City, State & Zip: _____Home Phone:_____
Cell Phone: _____ Work Phone: _____
E-mail: _____
Employer: _____ Occupation: _____
Relationship to Patient: _____ Lives with patient: _____

Preferred Method of Contact: Phone E-mail Text
Preferred Phone Number: Home Cell Work
*for appointment reminders

If parents are divorced, who has primary legal custody: _____
Who is declared "financially responsible" for the child's insurance?_____
Are there any legal restrictions that would prevent the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes/No.**
(If yes, please provide a copy of the legal paperwork that supports this restriction.)

_____

Name of Parent Completing Form (Print) **Signature** **Date**