Demographics

PATIENT

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

☐ enroll in Patient Portal **EMAIL: Primary** _____ **Secondary** _____

PARENT #1

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

Address _____ **City** _____ **State** ____ **Zip** _____

PHONE: Home _____ **Cell** _____ **Work** _____

Marital Status _____ **Employer Name** _____

SPOUSE: Name _____ **Date of Birth** _____

PARENT #2

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

Address _____ **City** _____ **State** ____ **Zip** _____

PHONE: Home _____ **Cell** _____ **Work** _____

Marital Status _____ **Employer Name** _____

SPOUSE: Name _____ **Date of Birth** _____

EMERGENCY CONTACT (OTHER THAN PARENT)

NAME: Last _____ **First** _____ **Middle** _____

Phone Number _____ **Relationship to Patient** _____

SIBLINGS

Please list siblings that are currently patients of Salem Pediatric Clinic on page 2 of this form.

THIS INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signed by _____ **Date** _____

Print Name _____ **Relationship** _____

SPC ONLY

PCP _____

R ____ **D** ____

Salem Pediatric Clinic

2478 13th Street SE
Salem, Oregon 97302
503-362-2481 · Phone
503-371-7803 · Fax
SalemPediatricClinic.com

Demographics

SIBLING #1

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

SIBLING #2

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

SIBLING #3

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

SIBLING #4

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

SIBLING #5

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

SIBLING #6

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

SIBLING #7

NAME: Last _____ **First** _____ **Middle** _____

Date of Birth _____ **Social Security Number** _____ **Gender** _____

RESIDES WITH: Name _____ **Relationship to Patient** _____

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