**Patient Demographic Form:** revised 10/19


Robert J. Lobonc, M.D.

**PATIENT INFORMATION**

Patient: Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ AGE:_____ Sex: ☐Male ☐ Female Preferred name: _____

Mailing Address:_____ City/State/Zip:_____

Primary Phone: (_____) _____ (Home or Cell) Secondary Phone: (_____) _____ (Home or Cell)

Main Pharmacy Name:_____ Phone:_____

Secondary Pharmacy Name:_____ Phone:_____

**Emergency Contact (NOT LIVING WITH PATIENT)**

Name:_____ Relationship:_____ Phone:_____

**Marital Status of Parents (circle ONE): Married Separated Divorced Widowed Single**

**MOTHER/GUARDIAN**

Name:_____

DOB:_____ Lives with patient? Yes or No

Address:_____

City/State/Zip:_____

Primary Phone: (_____) _____ (home or cell)

Email:_____

Employer:_____

Occupation:_____

**FATHER/GUARDIAN**

Name:_____

DOB:_____ Lives with patient? Yes or No

Address:_____

City/State/Zip:_____

Primary Phone: (_____) _____ (home or cell)

Email:_____

Employer:_____

Occupation:_____

**Responsible Party- (self, if 18 or older) parent or legal guardian (if under 18)**

**Last Name:**_____ **First Name:**_____ **MI:**_____

**DOB:**_____ **Social Security #:**_____ **Phone:**_____

**Address of Person Responsible:**_____

**City/State/Zip:**_____ **Relationship to Patient:**_____

**Insurance Information:**

Primary Insurance Co:_____

Policy Holder Name:_____

ID #:_____ Group #:_____

Effective Date:_____

Secondary Insurance Co:_____

Policy holder Name:_____

ID #:_____ Group #:_____

Effective Date:_____

**Insurance payment authorization and release: I hereby authorize my insurance benefits to be paid directly to Boonslick Pediatrics, L.L.C. and acknowledge I am financially responsible for any unpaid balance and/or collection fees that may apply. I also authorize the release of any information to my insurance company.**

☐ Yes, I agree ☐ No, I do not agree

**E-Prescription Consent for Medication:**

**With my consent, Boonslick Pediatrics may submit prescription medications utilizing their e-prescription feature.**

☐ Yes, I consent ☐ No, I do not consent

**Additional Information:**

How did you hear about our practice: _____

**Signature of Patient or Legal Guardian:**_____ **Date:**_____