



7693 Rhea Co Hwy Ste 1  
Dayton, TN 37321  
(423) 594-8700

### Family Demographic Form

**Patient Information – Please include each child that will be our patient** (If you have more than 4 children please ask for a 2<sup>nd</sup> Demographic Form)

**Child No. 1** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Preferred Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Ethnicity  Non-Hispanic  Hispanic  I Decline to Answer

Race  American Indian/Alaskan Native  Asian  Black  White  Hawaiian/Pacific Islander  I Decline to Answer

**Child No. 2** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Preferred Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Ethnicity  Non-Hispanic  Hispanic  I Decline to Answer

Race  American Indian/Alaskan Native  Asian  Black  White  Hawaiian/Pacific Islander  I Decline to Answer

**Child No. 3** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Preferred Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Ethnicity  Non-Hispanic  Hispanic  I Decline to Answer

Race  American Indian/Alaskan Native  Asian  Black  White  Hawaiian/Pacific Islander  I Decline to Answer

**Child No. 4** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Preferred Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female Ethnicity  Non-Hispanic  Hispanic  I Decline to Answer

Race  American Indian/Alaskan Native  Asian  Black  White  Hawaiian/Pacific Islander  I Decline to Answer

**Please list the physical address for the children listed above. If children split their time between two homes, all children do not live at the same home, or there are any other special circumstances or living arrangements, please check here:**  Physical Address \_\_\_\_\_

**Mailing Address** \_\_\_\_\_

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

**Primary Contact Number** \_\_\_\_\_  Land  Cell Belongs to? \_\_\_\_\_

**2ndary Contact Number** \_\_\_\_\_  Land  Cell Belongs to? \_\_\_\_\_

**Child(ren) Cell Number**

Number _____	First Name _____	Number _____	First Name _____
Number _____	First Name _____	Number _____	First Name _____

**Emergency Contact**

Name: \_\_\_\_\_ Number: \_\_\_\_\_  Land  Cell

**Family Language Preference**

English  Spanish  Other \_\_\_\_\_

**Is the Primary Caregiver:** Visually Impaired  Yes  No Hearing Impaired  Yes  No

**Would you like an interpreter for medical communications?**  Yes  No

(Continued on other side)

**Parent/ Legal Guardian No. 1**

\_\_\_\_\_  
Last Name                      First Name                      MI                      Date of Birth                      Social Security Number

Relationship to Child \_\_\_\_\_  Lives with Child  Person responsible for bill

\_\_\_\_\_  
Mailing Address (if Different than Child)

**Parent/ Legal Guardian No. 2**

\_\_\_\_\_  
Last Name                      First Name                      MI                      Date of Birth                      Social Security Number

Relationship to Child \_\_\_\_\_  Lives with Child  Person responsible for bill

\_\_\_\_\_  
Mailing Address (if Different than Child)

**Insurance Information**

Primary Insurance Company: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Your privacy is very important to us. There are times that we will reach out to you to follow up with you regarding your treatment, payment and healthcare operations, appointment reminders, insurance questions, patient statements and other items pertaining to your care. For convenience sake, we offer email and text messaging reminders and notifications. We will not send sensitive issues via these routes, nor on voicemail, but a follow up call might be necessary to share the pertinent information. Please check any of the following ways you would like us to communicate with you. If you have any questions or needs, please contact Allyson Blaylock, Practice Administrator at (423) 594-8700 or via email at [blaylock@fireflypediatrics.org](mailto:blaylock@fireflypediatrics.org).

Please list any restrictions to how we may contact you (ex: you may not leave messages on voicemail):

\_\_\_\_\_  
 You may leave messages (with a person or voicemail) at \_\_\_\_\_ or \_\_\_\_\_

You may text me at the following cell phone number(s) \_\_\_\_\_

Please sign me up for the Patient Portal and informational email messages. The e-mail address I would like to use is: \_\_\_\_\_ and belongs to  Mom  Dad  Legal Guardian

Signed: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient:  
\_\_ mother \_\_ father \_\_ legal guardian \_\_ other: \_\_\_\_\_