

Demographics

PATIENT

NAME: Last _____ First _____ Middle _____

Date of Birth _____ Social Security Number _____

Gender _____ Race (Optional) _____ Primary Language _____

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 _____ Race (Optional) _____ Primary Language _____

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 _____ Race (Optional) _____ Primary Language _____

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 _____ Race (Optional) _____ Primary Language _____

RESIDES WITH: Name _____ Relationship to Patient _____

SIBLING # 2

NAME: Last _____ First _____ Middle _____

Date of Birth _____ Social Security Number _____

Gender _____ Race (Optional) _____ Primary Language _____

RESIDES WITH: Name _____ Relationship to Patient _____

SIBLING # 3

NAME: Last _____ First _____ Middle _____

Date of Birth _____ Social Security Number _____

Gender _____ Race (Optional) _____ Primary Language _____

RESIDES WITH: Name _____ Relationship to Patient _____

SIBLING # 4

NAME: Last _____ First _____ Middle _____

Date of Birth _____ Social Security Number _____

Gender _____ Race (Optional) _____ Primary Language _____

RESIDES WITH: Name _____ Relationship to Patient _____

SIBLING # 5

NAME: Last _____ First _____ Middle _____

Date of Birth _____ Social Security Number _____

Gender _____ Race (Optional) _____ Primary Language _____

RESIDES WITH: Name _____ Relationship to Patient _____

SIBLING # 6

NAME: Last _____ First _____ Middle _____

Date of Birth _____ Social Security Number _____

Gender _____ Race (Optional) _____ Primary Language _____

RESIDES WITH: Name _____ Relationship to Patient _____

SIBLING # 7

NAME: Last _____ First _____ Middle _____

Date of Birth _____ Social Security Number _____

Gender _____ Race (Optional) _____ Primary Language _____

RESIDES WITH: Name _____ Relationship to Patient _____



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