Bayou Pediatric Associates New Patient Form

_____ _____ _____

Last Name First Name Middle Name

_____ _____ Male or Female

Date of Birth Social Security Number (Circle one)

_____ _____ _____

Address Home Phone Number Cell Phone Number

_____ _____ _____ _____ _____

City State Zip Code Work Phone Number Alternate Phone Number

_____

Email Address

At Bayou Pediatric Associates we utilize electronic health records. The following information is required to create your child's chart. Thank you. Please mark an X next to what applies to your child.

| **Preferred Language** | **Race** | **Ethnicity** |
|---|---|---|
| English | African American | Hispanic |
| French | Asian | Non-Hispanic |
| Spanish | Caucasian | |
| Vietnamese | Native American | |
| Other | Multi-Racial | |

_____ _____ _____ _____

Mother's Name DOB Father's Name DOB

Please fill out the insurance information that applies to your family as listed below:

Primary Insurance _____ Policy Number _____
Card Holder Name _____ Social Security Number _____
Relationship to the Patient _____ Policy Holder DOB _____

Secondary Insurance _____ Policy Number _____
Card Holder Name _____ Social Security Number _____
Relationship to the Patient _____ Policy Holder DOB _____

Medicaid/Bayou Health Plan Circle One
United Healthcare Amerigroup LA Healthcare