ROCKCASTLE PEDIATRICS PATIENT INFORMATION

Full Patient Name: (First, Middle, Last)
____
Patient likes to be called: ______________________
Primary Language: ____________________________
Date of Birth: ________________________________
Gender: Male / Female
Patient's Soc Sec #: ___________________________

Mailing Address: ______________________________
City: _________________________ State: _______
Zip: _________ County: ______________________
Best Contact Phone #: ________________________
Email: ____________________________________

Does Patient live with both parents: YES / NO
If not, who is the legal guardian? (name and relationship) ____________________________
Would you like your child's health info to be shared with other hospitals? YES / NO

Primary Insurance: ___________________________
Policy Holder's Name: _________________________
Policy Holder's Soc Sec #: _____________________
Policy Holder's D.O.B: ________________________
Policy Holder's relationship to patient: ____________

Secondary Insurance: _________________________
Policy Holder's Name: _________________________
Policy Holder's Soc Sec #: _____________________
Policy Holder's D.O.B: ________________________
Policy Holder's relationship to patient: ____________

Drug Allergies: ______________________________
Pharmacy: _________________ Location: ________
School: ______________________Grade: ________

If needed, may we text message the cell phone number(s) you have provided on this page? YES / NO

I consent to my healthcare provider, and any staff they designate, to be able to take and view images (such as photographs or videos) for my care or identification. I understand and agree that some of these images may be retained, while others are for real-time monitoring only. YES / NO

Patient's Race:
- ☐ Asian
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Other: ______________________________

Patient's Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Mother's Name: ______________________________
Mother's DOB: _______________________________
Mother's Soc Sec #: ___________________________
Mother's Maiden Name: ________________________
Mother's Cell #: ______________________________
Father's Name: _______________________________
Father's DOB: ________________________________
Father's Soc Sec #: ___________________________
Father's Cell #: ______________________________

I have been provided with a copy of the Patient Privacy Practices Brochure: YES / NO

FOR MINOR PATIENTS 16 YEARS OF AGE OR OLDER:
☐ I authorize the minor patient referenced above to seek care and treatment, including vaccines, without a parent/guardian present (except for school and sports physicals).

____
Signature Relationship to Patient

____
Phone Number Date

Fill out this section to allow another adult to bring your child to the office: The following person(s) (who is/are not a parent/guardian) may be contacted in an emergency and may bring and sign for the patient to receive medical treatment, and/or receive protected health information:
Name: ______________________________________ Relationship: __________________________
Phone: ____________________________
Name: ______________________________________ Relationship: __________________________
Phone: ____________________________

SIGNATURE OF GUARDIAN: ____
DATE: _______________