

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) _____

Primary Insurance: _____

Policy Holder's Name: _____

Policy Holder's Soc Sec #: _____

Policy Holder's DOB: _____

Policy Holder's relationship to patient: _____

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Holder's Soc Sec #: _____

Policy Holder's DOB: _____

Policy Holder's relationship to patient: _____

Drug Allergies: _____

Pharmacy: _____

Pharmacy Location: _____

School: _____ Grade: _____

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

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

Would you like your child's health info to be shared with other hospitals? 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 child's 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 #: _____

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

SIGNATURE OF GUARDIAN: _____

DATE: _____