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: _____