ROCKPEDS PATIENT INFORMATION FORM – 2017

Rockcastle Pediatrics • 140 Newcomb Ave • Mt. Vernon KY 40456
phone: 606-256-4148 • fax: 606-256-7785

Patient Name_____
Name Patient likes to be called_____
Mailing Address _____
City_____State____ Zip_____
County _____
Best Contact Phone #_____

Does Patient Live with Both Parents? **Y / N**
If not, who is the legal guardian (name and relationship)?
_____

Other than parents/guardians, whom may we contact in an emergency?
Name_____
Phone_____
Relationship_____

Primary Insurance_____
Policy Holder's Name_____
Policy Holder's Soc Sec#_____
Policy Holder's Date of Birth_____
Policy Holder's Relationship to Patient_____

Secondary Insurance_____
Policy Holder's Name_____
Policy Holder's Soc Sec #_____
Policy Holder's Date of Birth_____
Policy Holder's Relationship to Patient_____

Drug Allergies_____
Pharmacy_____Location_____
School Patient attends_____
Grade Level_____
If needed may we text message the cell phone #s you have provided on this page? **Y / N**
I have been provided a copy of the Privacy Practices Brochure: **Y / N**

Patient's Soc Sec # _____

Please Circle Patient's Race:
- Asian
- Black or African American
- American Indian or Alaska Native
- Native Hawaiian or Pacific Islander
- White
- Unknown

Please Circle Patient's Ethnicity:
- Hispanic or Latino
- Not Hispanic or Latino

Primary Language_____
Religion_____
Date of Birth_____
Gender: Male Female

Mother's Name_____
Mother's Date of Birth_____
Mother's Soc Sec#_____
Mother's Maiden Name_____
Mother's Cell#_____
Mother's work#_____

Father's Name_____
Father's Date of Birth_____
Father's Soc Sec#_____
Father's Cell#_____
Father's Work#_____

Other children/siblings living in Patient's home:
Name_____ Date of Birth_____
Name_____ Date of Birth_____
Name_____ Date of Birth_____
Name_____ Date of Birth_____

Please fill out this section if you want to grant permission to another responsible adult to bring your child to the office: I give permission to the following person (who is not a parent or guardian of the Patient) to bring the Patient to the office for medical attention, to sign for treatment, and/or receive protected health information: Name_____Address_____Phone_____
Relationship to Patient_____ This person is an adult over the age of 21: **Y / N**

SIGNATURE OF PARENT/ GUARDIAN_____DATE_____