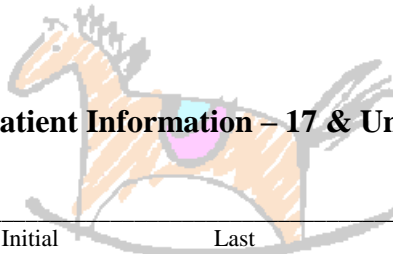


Patient Information – 17 & Under



Today's Date: ___/___/___

Patient's Name: _____ Birth Date: ___/___/___
First Middle Initial Last

Patient Address: _____ City/State: _____ Zip: _____

Sex: Male Female SS#: _____-_____-_____

Please list the BEST Phone #s for contact and reminder calls:

Email Address: _____
(No protected health information will be sent via email)

Phone #1: _____

Phone #2: _____

How should we contact you? Phone Email Postal Mail

**Responsible Party/Guarantor (If different from patient)

Mother or Primary Guardian's Name: _____

SS#: _____-_____-_____ Birth Date: ___/___/___ Check Box if Address the same as patient's above?

Address: _____ Phone #: _____

Employer: _____ Work Phone #: _____

Father or Secondary Guardian's Name: _____

SS#: _____-_____-_____ Birth Date: ___/___/___ Check Box if Address the same as patient's above?

Address: _____ Phone #: _____

Employer: _____ Work Phone #: _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

**Please answer the following questions regarding the PATIENT: (Your answers are CONFIDENTIAL and are used for statistic purposes only)

Please mark which insurance is the PRIMARY insurance type for the patient:

- Medicaid Caresource (need PCP) Molina Amerigroup United Health Care No Insurance
- Aetna PPO Aetna HMO (need PCP) Medical Mutual Anthem Blue Cross/Blue Shield Other: _____

Patient's RACE? (mark all that apply) White Black/African American Native Hawaiian Asian
 American Indian/Alaska Native Other Pacific Islander Other: _____

Hispanic/Latino? YES NO If yes: Mexican Puerto Rican Cuban Other Hispanic

Primary Language? English Spanish Other: _____

Homeless? YES NO If yes, where are you living? Shelter Transitional Doubling up Street Other

Migrant Farm Worker? YES NO Seasonal Farm Worker? YES NO

Because we receive federal funds to help us offer care to the uninsured, we are required to ask about the income of all of our patients and families.

Total Household Income? \$ _____ Weekly Monthly Annually

How many people are living in your household? _____ people

****ALL information will be kept CONFIDENTIAL****



Rocking Horse Community Health Center Emergency Contact Information

Patient's Name: _____ Birth Date: ____ / ____ / ____

Please list any other family members that Rocking Horse Community Health Center may inform about the patient's general medical condition and diagnosis including instructions for treatment or billing questions in the event that you, the patient or the patient's legal guardian, is not available. The people in the below section may serve as the patient's personal representative.

Must be 18 years and older to be contacted

Name Relationship to Patient Phone #

Name Relationship to Patient Phone #

Name Relationship to Patient Phone #

Can confidential messages (example: appointment reminders, notification of labs or other results)

be left on your telephone answering machine or voicemail? YES NO

**** We will never leave detailed information on an answering machine or voicemail ****

Pharmacy Name: _____

Address/Location: _____ City/State: _____

By signing below,

- ✓ I give consent for Rocking Horse Community Health Center to use the above personal representative information as described above.
- ✓ I understand that cell phones are not secure lines.

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____

***** This will remain in effect until revoked by the patient or guardian. Documentation will be updated annually. ****