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#: _____-_____-_____

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

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

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. ****