ROCKCASTLE PEDIATRICS PATIENT INFORMATION – 2020

Rockcastle Pediatrics 140 Newcomb Ave Mt. Vernon, KY 40456
Phone: (606) 256-4148 Fax: (606) 256-7785

Full Patient Name (First, Middle, Last):

____

Patient likes to be called: ________________________
Mailing Address: ______________________________
City: ________________ State: ___________________
Zip: ___________ County: _______________________
Best Contact Phone #: __________________________
Email Address: _______________________________

Does Patient live with both parents? ☐YES ☐NO
If not, who is the legal guardian? (name and relationship) ___________________________________

Would you like your child's health info to be shared with other hospitals? ☐YES ☐NO

Other than parents/guardians, who may we contact in an emergency?
Name: ____
Phone: _______________________________________
Relationship: __________________________________

Primary Insurance: ______________________________
Policy Holder's Name: ___________________________
Policy Holder's Soc Sec #: ________________________
Policy Holder's D.O.B: ___________________________
Policy Holder's Relationship to Patient: _____________

Secondary Insurance: ____________________________
Policy Holder's Name: ___________________________
Policy Holder's Soc Sec #: ________________________
Policy Holder's D.O.B: ___________________________
Policy Holder's Relationship to Patient: _____________

Drug Allergies: _________________________________
Pharmacy: __________________ Location: __________
School Patient Attends: __________________________
Grade Level: ___________________________________

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

Patient's Soc Sec #: _______________________

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

Patient's Ethnicity:
- ☐Hispanic or Latino
- ☐Not Hispanic or Latino

Primary Language: _________________
Religion: _____________________
Date of Birth: _________________________
Gender: ☐Male ☐Female

Mother's Name: _________________________
Mother's D.O.B___________________________
Mother's Soc Sec #: ______________________
Mother's Maiden Name: __________________
Mother's Cell #: __________________________
Mother's Work #: ________________________

Father's Name: _________________________
Father's D.O.B__________________________
Father's Soc Sec #: ______________________
Father's Cell #: _________________________
Father's Work #: ________________________

Other Children/siblings living in Patient's home:
Name: _____________________ D.O.B: ______
Name: _____________________ D.O.B: ______
Name: _____________________ D.O.B: ______
Name: _____________________ D.O.B: ______
Name: _____________________ D.O.B: ______

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

Fill out this section to allow another responsible adult to bring your child to the office: The following person (who is not a parent or guardian of the Patient) may bring and sign for the patient to receive medical treatment, and/or receive protected health information: Name: ____
Address: ________________________ Phone: ____________________ Relationship to Patient: ___________________
This person is over the age of 21: ☐YES ☐NO

SIGNATURE OF PARENT OR GUARDIAN: ____DATE: ___________