ROCKCASTLE PEDIATRICS PATIENT INFORMATION – 2023

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: _____

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

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: _____Grade: _____

If needed, may we text message the cell phone number(s) you have provided on this page? 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 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 Soc Sec #: _____

Patient's Race:
- ☐ Asian
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Caucasian
- ☐ 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 DOB: _____
Mother's Soc Sec #: _____
Mother's Maiden Name: _____
Mother's Cell #: _____
Mother's Work #: _____

Father's Name: _____
Father's DOB: _____
Father's Soc Sec #: _____
Father's Cell #: _____
Father's Work #: _____

Other children living in the Patient's home:
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

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

Fill out this section to allow another adult to bring your child to the office: The following person(s) (who is/are not a parent/guardian) may be contacted in an emergency and may bring and sign for the patient to receive medical treatment, and/or receive protected health information:
Name: _____ Relationship: _____ Over age 21? YES / NO
Phone: _____
Name: _____ Relationship: _____ Over age 21? YES / NO
Phone: _____

SIGNATURE OF PARENT/GUARDIAN: _____ ***DATE:*** _____