



### PATIENT INFORMATION FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact Information: \_\_\_\_\_  
Name Relationship to patient Phone number

### Guardian Information

#### Legal Guardian

☐ MOTHER ☐ FATHER ☐ OTHER (specify): \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: (If DIFFERENT from patient's):

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### Legal Guardian

☐ MOTHER ☐ FATHER ☐ OTHER (specify): \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Email: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: (If DIFFERENT from patient's):

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Insurance Information

#### Primary Insurance

Company: \_\_\_\_\_

Policyholder: \_\_\_\_\_ DOB: \_\_\_\_\_

#### Secondary Insurance

Company: \_\_\_\_\_

Policyholder: \_\_\_\_\_ DOB: \_\_\_\_\_

I have reviewed this office's Notice of Privacy Practices, explaining how (above patient's) medical information will be used and disclosed.

I understand that I am entitled to receive a copy of this document, upon request.

I understand that it is the policy of River Ridge Pediatrics to respect patient's privacy and office policy prohibits video and audio recordings on any electronic device while in the office.

I understand that River Ridge Pediatrics will only use/or disclose PHI (protected health information) for treatment, payment or healthcare operations. Pursuant to Section 30.06, Penal Code (trespass by holder of license to carry a concealed handgun), a person licensed under Subchapter H, Chapter 411, Government Code (concealed handgun law), may not enter this property with a concealed handgun.

Pursuant to Section 30.07, Penal Code (trespass by license holder with an openly carried handgun), a person licensed under Subchapter H, Chapter 411, Government Code (handgun licensing law), may not enter this property with a handgun that is carried openly.

Conforme a la Sección 30.06 del Código Penal (ingreso sin autorización de un portador de una licencia para llevar un arma corta oculta), una persona con licencia según el Subcapítulo H, Capítulo 411, del Código del Gobierno (ley para portar armas cortas ocultas), no pueden ingresar a esta propiedad con un arma corta oculta.

Conforme a la Sección 30.07 del Código Penal (ingreso ilegal de un portador de una licencia para llevar una arma corta de mano a vista), una persona con licencia según el Subcapítulo H, Capítulo 411, del Código del Gobierno (ley de licencias de armas de fuego), no puede ingresar a esta propiedad con una arma de fuego que se lleve libremente.



\_\_\_\_\_  
Name of Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date