DATE: _____

PATIENT INFORMATION Please print in blue or black ink

Patient Name: _____ _____ _____ □ Male □ Female
Last First MI

DOB: _____ Age: _____ Social Security # _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Life Partner

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined
Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Address: _____Apt # _____ City_____ St_____ Zip _____

Phone: Home_____Cell_____ Work_____

E-Mail_____ By providing my email, I give RCH consent to communicate with me by email

Employer: _____

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, or if patient is a minor, please complete section below)*

Name: Last_____ First_____ MI_____ □ Male □ Female

DOB: _____ Relationship: □ Spouse □ Parent □ Guardian □ Other (Please Specify): _____

Address: _____Apt #_____ City_____St_____Zip _____

Phone: Home_____ Cell_____ Work_____

Email Address _____

Employer: _____

EMERGENCY CONTACT *(Closest relative not living with you)*

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

PRIMARY CARE PHYSICIAN (PCP)

Name: _____ Phone: _____

Continue to the Back of this Page

FOR OFFICE USE ONLY: *Patient Name*_____
*MRN*_____

Please provide a copy of all Insurance Cards and a Driver's License / Photo ID
You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

INSURANCE INFORMATION

Medicare ID# _____

Medicare Supplement _____ ID# _____

Medicare Advantage Plan _____ ID# _____

Medicaid ID# _____

Commercial Insurance

Primary Insurance_____ ID _____ Group: _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

Secondary Insurance_____ ID: _____ Group _____

Policy Holder Name:_____ Relationship (Circle One) Self Spouse Parent Other _____

SS#_____ Policy Holder's DOB_____ Employer_____

Authorization to Treat a Minor (Ages 0-18th Birthday) □ Not Applicable (patient is an adult)

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Ringgold County Hospital to discuss or disclose information regarding any matters relating to my child's, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Ringgold County Hospital of changes or update. I authorize Ringgold County Hospital to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

How did you hear about us?

□ Friend/Family Member □ Physician □ Drive by □ Internet □ Social Media □ Radio □ Newspaper □ School □ Event