RGH Clinics
Patient Information Sheet

Patient Information

Last Name_____First Name_____ MI_____

Physical Address _____City _____State_____ Zip_____

Home Phone_____ Cell Phone _____ County_____

Date of Birth_____ Gender_____ Primary Language_____

Race (choose one): ◯White ◯Asian ◯Black/African American ◯American Indian/Alaskan native
◯Native Hawaiian/Pacific Islander ◯Other/Unknown/Declined to Specify

Ethnicity (choose one): ◯ Hispanic/Latino ◯ Non-Hispanic ◯ Declined to Specify ◯ Unknown

Guarantor

Responsible Party _____ Relationship to Patient_____

Mailing Address _____ ***City*** _____ ***State***_____ ***Zip***_____

Date of Birth_____ Home/Cell Phone_____ Work Phone_____

Emergency Contact Information

Name_____ Relationship to Patient_____

Home/Cell Phone_____ Work Phone_____

Preferred Method of Contact

Preferred Method of Contact ◯ Phone ◯ Email ◯ Patient Portal ◯ Other

Do we have your permission to leave a detailed message including test results? ◯ Yes ◯ No

Email Address_____

Pharmacy Information

Pharmacy Name_____ Phone Number_____

Please note, 2nd page on back

Insurance

Primary Insurance Carrier_____ Address_____

Subscriber Name_____ Relationship to Patient_____

Member ID_____ Group Number_____

Workers Compensation Carrier

Motor Vehicle Insurance Information

Insurance Company Name_____Phone_____

Address_____ City _____ State_____ Zip_____

Claim Number_____ Contact Person_____

Date of Injury_____ Subscriber Name_____ Relationship to Patient_____

Employer

Employment Status ◯Employed ◯Self-employed ◯Retired ◯On active military duty ◯Unknown

Employer Name_____

Employer Address _____ Phone_____

Signature

I verify that the above information is factual and true to the best of my knowledge. I understand that proof of insurance and/or copay, if applicable, is due at the time of service.

Patient or Legal Guardian Signature_____ Date_____

Authorization to Release Medical Information

Please check one:

I authorize Rio Grande Hospital and Clinics to release my medical information including the diagnosis, examination rendered to me, treatment to:

◯ Spouse _____

◯ Child(ren)_____

Other_____

◯ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.