



Rio Grande Hospital & Clinics

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____

Physical Address _____ City _____ State _____ Zip _____

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

Home Phone _____ Cell Phone _____ County _____

Date of Birth _____ SSN(Veterans Only) _____ Primary Language _____

Email Address _____ Mothers Maiden Name _____

Birth Sex: Female Male

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

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

Gender Identity: Identifies as Female Identifies as Male FTM/Trans Male/Trans Man
 MTF/Trans Female/Trans Woman Genderqueer, neither male or female Choose not to disclose

Sexual Orientation: Straight or heterosexual Lesbian, gay or homosexual Bisexual Choose not to disclose

Guarantor (Responsible Party)

Parent/Guardian _____ Relationship to Patient _____

Date of Birth _____ Home Phone _____ Cell Phone _____

Emergency Contact Information

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____

Primary Care Provider

Provider Name _____ Phone Number _____

Insurance (If copy was obtained, do not complete this section)

Check if photocopy of Insurance Card complete

Primary Insurance Carrier _____ Address _____

Subscriber Name _____ Relationship to Patient _____

Member ID _____ Group Number _____

Workers Compensation or Motor Vehicle Insurance Information

Check if Medical Care sought due to work related injury

Check if involved in a Motor Vehicle Accident

Insurance Company Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Claim Number _____ Contact Person _____

Date of Injury _____ Subscriber Name _____ Relationship to Patient _____

Employer (Only if Workman's Comp)

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 _____