Children's Hospital

Adult Patient Information

Patient

Primary Care Physician: ______________________________

Last Name: ______________________ First: ______________________ Mid: __________

DOB: ___/___/______ Sex: Male/Female SSN: ______-_____-________ Email: ______________________

Address: ______________________________________ Primary Phone: ☐ Home ☐ Cell

Home Phone: (____)______ - ________

City: ____________________ State: ______ Zip: ____________ Cell Phone: (____)______ - ________

Employer: ______________________________________ ☐ Full time ☐ Part time

Address: ____

Spouse/Parents

Last Name: ______________________ First: ______________________ Mid: __________

DOB: ___/___/______ Sex: Male/Female SSN: ______-_____-________ Email: ______________________

Address: ______________________________________ Primary Phone: ☐ Home ☐ Cell

City: ____________________ State: ______ Zip: ____________ Home Phone: (____)______ - ________

Cell Phone: (____)______ - ________

Employer: ______________________________________ Ok to leave message: (Y / N)

Address: ______________________________________ Work Phone: (____)______ - ________

City: ____________________ State: ______ Zip: ____________

Emergency Contact

Relation: ______________________

Last Name: ______________________ First: ______________________ Mid: __________

Address: ______________________________________ Home Phone: (____)______ - ________

City: ____________________ State: ______ Zip: ____________ Cell Phone: (____)______ - ________

Patient

Race: ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Hispanic ☐White ☐Other

Ethnicity: ☐Non-Hispanic ☐Hispanic/Latino ☐Refused to report

Preferred Language for healthcare discussion: ☐English ☐Spanish ☐Other______________________

(continued on back)

Insurance Information (Primary)

Insured's Last Name: ______________________ First: ______________________ MI: ____

Relationship to Patient: ______________________ DOB: ___/___/_____ SSN: _____-____-_______

Insured Address: ______________________________ Phone: (____)_____ - _________

City: ____________________ State: _____ Zip: __________

Insurance Name: ______________________________ Effective Date: ___/___/_____

Employer Name: ______________________________

Insurance Information (Secondary)

Insured's Last Name: ______________________ First: ______________________ MI: ____

Relationship to Patient: ______________________ DOB: ___/___/_____ SSN: _____-____-_______

Insured Address: ______________________________ Phone: (____)_____ - _________

City: ____________________ State: _____ Zip: __________

Insurance Name: ______________________________ Effective Date: ___/___/_____

Employer Name: ______________________________

Pharmacy

1) Name: ______________________________ Phone: (____)_____ - _________

Address: ____

2) Name: ______________________________ Phone: (____)_____ - _________

Address: ____

Preferred Communications

Phone call: ☐

Text messaging: ☐

Preferred Phone: (____)_____ - _________

Preferred Language: ☐ English ☐ Spanish

Preferred Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Send Reminder/Follow-up Letters: ☐

Send Reminder/Follow-up Emails: ☐

Type of Reminders/Follow-up:

- Select All ☐
- Appointments ☐
- Lab results ☐
- Health Maintenance ☐
- Rx Confirmation ☐
- General Notification ☐

I give consent for ETCH to exchange information with the individuals listed on this form.

______________________________ ______________

Patient Signature **Date:**