## THOMPSON RIVER PEDIATRICS AND URGENT CARE
## PATIENT INFORMATION FORM

(PLEASE PRINT)

PATIENT NAME: ______________________________ DATE OF BIRTH: ______________

HOME PHONE #: ______________________________ CELL PHONE # ______________

ANY OTHER NAMES PATIENT HAS GONE BY: ______________________________

GENDER: __FEMALE __MALE PATIENT'S SS #: ____-____-________

RACE: __CAUCASIAN __NATIVE AMERICAN __HISPANIC __AFRICAN AMERICAN __ASIAN
__OTHER: ______________________________

ETHNICITY: __HISPANIC __NON-HISPANIC

MAILING ADDRESS: ______________________________

CITY: ______________________________ STATE: __________ ZIP:__________

RESPONSIBLE PARTY (GUARANTOR): ______________________________

INSURANCE HOLDER NAME: ______________________________

INSURANCE COMPANY: ______________________________NUMBER: ______________

DOB: ______________RELATIONSHIP TO PATIENT: _____MOTHER ____FATHER OTHER: ______________

MOTHER'S NAME: ______________________________ MAIDEN NAME: ______________

DOB: ______________________ SS#: ______________________

ADDRESS: ______________________________

CITY: ______________________________ STATE: __________ ZIP: ______________

HOME PHONE: ______________________________ CELL PHONE: ______________________

PLACE OF EMPLOYMENT: ______________________________ PHONE # ______________

FATHER'S NAME: ______________________________

DOB: ______________________ SS#: ______________________

ADDRESS: ______________________________

CITY: ______________________________ STATE: __________ ZIP: ______________

HOME PHONE: ______________________________ CELL PHONE: ______________________

PLACE OF EMPLOYMENT: ______________________________ PHONE # ______________

FOSTER PARENT/GUARDIAN (IF APPLICABLE): ______________________________

ADDRESS: ______________________________

CITY: ______________________________ STATE: __________ ZIP: ______________

HOME PHONE: ______________________________ CELL PHONE: ______________________

PLACE OF EMPLOYMENT: ______________________________ PHONE # ______________

CASE WORKER: ______________________________

PREFERRED EMAIL: ______________________________

WHO MAY WE CONTACT OTHER THAN YOURSELF, IN CASE OF EMERGENCY:

______________________________ PHONE#: ______________________

RELATIONSHIP TO PATIENT: ______________________

ADDITIONAL FAMILY MEMBERS SEEN IN OUR OFFICE: ______________________________

HOW DID YOU HEAR ABOUT US? ______________________________