**PATIENT INFORMATION PLEASE PRINT CLEARLY**

Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex **M F**  Date of Birth\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_\_

Home Phone ( )\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Cell Phone ( )\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Physical Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race: [ ]** American Indian or Alaskan **[ ]** Asian **[ ]** Black or African American **[ ]** White **[ ]** Hispanic **[ ]** Other

**Primary Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GENERAL INFORMATION**

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: ( )\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: ( )\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( )\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Present Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Referred By: Physician Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Person’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone ( )\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Health Insurance Company name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# or CERT#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy # \_\_\_\_\_\_\_\_\_\_\_\_

Other Health Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fill out HIPPA information on back**

**DISCLOSURE OF PATIENT PROTECTED HEALTH INFORMATION**

In general, the HIPPA privacy act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also providing the right to request confidential communications or that a communication of PHI be made by alternate means, such as sending correspondence to the individual’s office instead of the individual’s home. I wish to be contacted in the following manner,

**Check all that apply: Choose one of the following: Check all that apply:**

**Telephone Written Communication Authorized PHI Recipients**

Leave Detailed Message at home □Y □N Ok to mail to my home □Y □N Spouse □Y □N

Leave call back Number at home □Y □N Ok to mail to mu work/office □Y □N Parent □Y □N

Leave Detailed Message at work □Y □N Ok to fax to this Child number □Y □N Child □Y □N

Leave Detailed Message on cell □Y □N Other (Relationship) □Y □N

□ **No Restriction Requested**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Parent or Legal Guardian Date*

**PHOTO RELEASE DISCLOSURE**

I hereby give permission for my image or the image of a minor under my guardianship to be taken at Alamo Children’s Heart Center (includes: photograph and or video) and to be posted on their Facebook page.

By signing below, I understand that the images will be located on the ACHC Facebook page and can be seen by people who have access to the account. For security reasons. No will be used, unless otherwise noted\*.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Minors Name (Print) D.O.B.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Parent or Legal Guardian Date*