PATIENT DATA FORM - River Park Medical Clinic

Patient Information

Patient Last Name	Middle Initial
Patient First Name	Date of Birth
Address	
City	
State	Zip
Home Phone #	Cell Phone #
Work Phone #	Work Phone Extension

Sex
☐ Male
☐ Female

Marital Status
☐ Single ☐ Divorced
☐ Married ☐ Widowed

Social Security

Employer Name

Occupation

Patient's Email Address

Patient's Race
☐ American Indian/Alaska Native
☐ Asian ☐ Black/African American
☐ White ☐ Prefer to not answer
☐ Hispanic ☐ Native Hawaiian/Pacific Islander
☐ Other

Ethnicity
☐ Hispanic/Latino ☐ Prefer to not answer
☐ Non Hispanic/Latino

Preferred Language
☐ Prefer to not answer

Emergency Contact Information

Emergency Contact Name	
Emergency Contact Home Phone #	Emergency Contact Cell/Work Phone #
Relationship to Patient	

Is the patient responsible for payments on this account? ____NO ____YES

If NO, please fill out the responsible party information below.

Responsible Party Last Name	Date of Birth
Responsible Party First Name	Sex ☐ Male ☐ Female
Responsible Party Address	
City	
State	Zip

Responsible Party Home Phone

Responsible Party Cell Phone

Relationship to Patient

If the responsible party is not the spouse or parent to a minor patient, then POA paperwork must be provided. If the responsible party is not the spouse, parent, or POA, please complete Patient Care Communication Form.

Appointment Contact

Who should we contact for appointments?	Preferred Phone #	Can we text to this #?

Pharmacy Information

Name of Preferred Pharmacy	Address of Preferred Pharmacy	Pharmacy Phone #

X _____ Date _____

Signature of Patient or Patient's Personal Representative

_____

If you are the Patient's Personal Representative, what is your relationship to the patient?

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