Martin D. Rudloff, MD, PC * 851 East Fifth Street, Suite 124 * Washington, MO 63090
Phone (636)390-8880 * Fax (636)390-8886

PATIENT INFORMATION **Date:**

Last Name_____ First Name_____ MI_____ DOB_____/_____/_____

Address_____ City_____ State_____ Zip_____

SSN_____-_____-_____ Alias_____ ___Male____Female____ Patient Cell #_____Patient email_____

Race	Ethnic group	Language
☐ White	☐ Hispanic	☐ English
☐ Black or African American		
☐ Asian	☐ Non-Hispanic	☐ Spanish
☐ American Indian or Alaskan Native		
☐ Native Hawaiin or other Pacific Islander	☐ Other_____	☐ Other_____
☐ Other_____		
☐ Unknown or Decline	☐ Decline	

Student Status: Full time_____.Part Time_____ Home Schooled_____ Non-Student_____< 5 years old_____

Siblings_____

Mother/Guardian Last Name_____ First Name_____MI____DOB_____/_____/____

☐ Same Address as for Patient

Address_____ City_____ State_____ Zip_____

Home Phone_____Work Phone_____Ext._____ Cell Phone_____ SSN_____-_____-_____

Employer Name :_____

Father/Guardian Last Name_____ First Name_____MI____DOB_____/_____/_____

☐ Same Address as for Patient

Address_____ City_____State_____ Zip_____

Home Phone_____Work Phone_____Ext._____ Cell Phone_____ SSN_____-_____-_____

Employer Name :_____

CONTACT PREFERENCES (Example Mom or dad, Check preferred way of contacting) Can we leave message on recorder or voice mail? YES_____ NO_____

Contact Name	Home Phone	Work	cell	email
Primary				
Secondary				

EMERGENCY CONTACT (Other than parent)

Name_____ Relationship to Patient_____ Daytime Phone Number_____

Initials of person completing form_____ Date:_____

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RESPONSIBLE PARTY (One parent /guardian to whom we can send bills/correspondences. In cases of separation or divorce, this must be parent/guardian with whom child lives most of time. If it is court ordered the other parent/guardian is to be responsible, you must provide legal documentation). Check and initial below or complete if other

☐ As listed above for father	☐ As listed above for mother	☐ Other–provide complete information below

Last Name_____First Name_____ MI_____ DOB_____/_____/_____

Address_____City_____ State_____Zip_____

Home Phone_____Work Phone_____Ext.__ _____ SSN_____-_____-_____

INSURANCE INFORMATION

Primary Insurance Company Name_____ Patient ID_____ Group_____

Primary Insurance Subscriber: Father_____ Mother_____ IF Other provide information below

Subscriber Last Name_____ First Name_____ MI_____ DOB_____/_____/_____

Subscriber Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____Ext._____

Employer_____ Subscriber Relationship to Patient_____SSN_____-_____-_____

Secondary Insurance Subscriber: Father_____ Mother_____ IF Other provide information below

Secondary Insurance Company Name_____ Patient ID_____ Group_____

Secondary Insurance Subscriber: Father_____ Mother_____ Other (Provide information below)

Subscriber Last Name_____ First Name_____ MI_____ DOB_____/_____/_____

Subscriber Address_____ City_____ State_____ Zip_____

Employer_____ Subscriber Relationship to Patient_____SSN_____-_____-_____

I grant Martin D. Rudloff, MD PC to contact me via email for the notification of office events, policies and results. Yes_____No_____Email not available_____

I will provide ALL current and effective insurance policy information to the office of Martin D. Rudloff, MD, PC. If failure occurs due to incomplete or misinformation, I will be responsible for all charges. I will be responsible for all charges incurred by this patient which are not covered by the insurance policy benefits. I authorize my insurance company to pay my physician directly, and I authorize the office of Martin D. Rudloff, MD, PC to release any information necessary to process claims. If collection fees are incurred, I will be responsible for those additional charges.

Signature Parent/Guardian_____Date_____