Rudolph Bolling Psychiatry, PC
Patient Information Form UPDATE
This is to be completed YEARLY or as there are changes.
(May be faxed to (844)270-4926)

For Medicaid recipients, a referral/ EPSDT is REQUIRED within the last year.

Date completing this form: _____

PATIENT DEMOGRAPHICS

Child's Name ***as it appears on Insurance card***: _____
Date of Birth: _____ Age: _____ Sex: Male/ Female
Social Security Number: _____
Race: [ ] Black [ ] Caucasian [ ] Hispanic [ ] Biracial [ ] Other _____
Address: _____
City: _____ State: _____ Zip Code: _____
[ ] Check here if any of the information in this section has changed in the last year/since last appt.

GUARDIAN INFORMATION

Guardian name: _____ Phone number: _____
Are you biological parent?: Yes/ No. **If not, please be sure to provide proof of guardianship.**
Is child adopted?: Yes/ No. If yes, does child know he or she is adopted?: Yes/ No
Is child in foster care? Yes/ No. If yes, what is the agency? _____
[ ] Check here if any of the information in this section has changed in the last year/since last appt.

PRIMARY PHYSICIAN INFORMATION

Name of primary doctor the child ***sees***: _____
Primary doctor's phone number: _____ Fax number: _____
When was child last seen by PCP? _____
Name of doctor ***Medicaid lists as primary physician***, if different: _____
[ ] Check here if any of the information in this section has changed in the last year/since last appt.

INSURANCE INFORMATION

Company: [ ] Medicaid [ ] AllKids [ ] Blue Cross [ ] Other: _____
ID & Group/ Medicaid Number: _____
If you have Medicaid, a referral/ current EPSDT IS REQUIRED EVERY YEAR*. Ask your PCP for details.
Please list any other medical insurance here: _____