Randolph County Health Department
1319 E. Highway 24
Moberly, MO 65270
Phone: 660-263-6643

PATIENT INFORMATION					
First Name	Middle	Last Name	Birth Date	Age	Gender

Address: ____ City/State/Zip: __________________________________

Home Phone: _____________________ Cell Phone: ______________________ Work Phone: ___________________

I give RCHD permission to text me reminding me about my appointments: ____ Yes _____No

E-mail address: ____

Employer: ____ Occupation: ____________________________________

If Minor:
Mother's Name: ____ Mother's Date of Birth _____________

Mother's Phone #: ____

Father's Name: ____ Father's Date of Birth _____________

Father's Phone #: ____

The Federal Government requires this information for Electronic Medical Records. You have the right to choose "decline"

Race:
- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Other
- ☐ Declined/Unknown

Ethnicity:
- ☐ Spanish/Hispanic Origin
- ☐ Not of Spanish/Hispanic Origin
- ☐ Declined/Unknown

Insurance: ____
ID: _________________________________ Group Number: ________________________________
Primary Insured Name: ____
Relationship to Patient: ________________________ Date of Birth: ___________________________
Does patient have a secondary insurance: _____________________

Person/guarantor responsible for payment of services (if different from patient)					
First Name	Middle	Last Name	Birth Date	Age	Gender

Address: ____ City/State/Zip: __________________________________

Home Phone: _____________________ Cell Phone: ______________________ Work Phone: ___________________

E-mail address: ____

Employer: ____ Occupation: ____________________________________

Emergency Contact (not within the same household)		
Name	Emergency Number (s)	Relationship to patient