Children's Clinic Patient Information Form

Patient Information:	Name: Last First MI (Legal Name)		
Mailing Address:			**County:**
City:	**State:**	**Zip:**	**Date of Birth**
Social Security #:		**Sex:** M F	
Email Address:	**Home Phone Number:**	**Cell Phone Number:**	
Emergency Contact:		**Phone:**	

Language:	English ☐	Spanish ☐	Japanese ☐ / Other ☐	Unavailable ☐
Ethnicity:	Non Hispanic ☐	Hispanic ☐	Declined ☐	Unavailable ☐
Race:	White ☐	Black/African American ☐	American Indian/ Alaska Native ☐	Asian ☐
	Native Hawaiian/Other Pacific Islander ☐	Multiracial ☐	Declined ☐	Unavailable ☐

Responsible Party Data (if other than patient):	Name: Last First MI		**Relation to Patient:**
Mailing Address:			
City:	**State:**	**Zip:**	**Date of Birth**
Social Security #:	**Home Phone Number:**	**Cell Phone Number:**	
Place of Work:		**Work Phone:**	

INSURED'S INFORMATION: *Our goal is to file your insurance correctly; a front and back copy of your current card will help ensure this. If you do not have insurance, please check with the front desk regarding payment options that are available.*

Primary Insurance Name:	**Secondary Insurance Name:**
Primary Policy Holder ID#:	**Secondary Policy Holder ID#:**
Primary Insured's Social Security #:	**Secondary Insured's Social Security #:**
Primary Insured's Date of Birth:	**Secondary Insured's Date of Birth:**
Primary Insurance- Insured's Name:	**Secondary Insurance- Insured's Name:**

Disclosure of Personal Health Information:

North Mississippi Medical Clinics will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those you authorize us to discuss your personal health information.

Contact Name	Relationship	Daytime Phone
Contact Name	**Relationship**	**Daytime Phone**
Contact Name	**Relationship**	**Daytime Phone**
Contact Name	**Relationship**	**Daytime Phone**

Patient/Guardian Signature: **Date:**