Children's Clinic Pediatric 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 Home Phone: Cell Phone:

Emergency Contact: Mother's Maider Name: Phone: Who can bring your child to the clinic?

How did you hear about us? ☐ Primary Care Provider Referral ☐ Specialist Provider Referral ☐ Patient Referral ☐ Hospital ☐ Insurance Company ☐ Internet Search ☐ Word of Mouth ☐ Advertising ☐ Other

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): **Primary Custodial Parent:** Last First MI Date of Birth

Mailing Address: City State Zip

Social Security #: Home Phone: Cell Phone:

Email Address: Employer: Work Phone:

Other Parent: Last First MI Date of Birth

Mailing Address (if different from above): City State Zip Contact 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: Insured's Date of Birth:

Primary Policy Holder's Name: Policy Holder ID#:

Primary Insured's Social Security #: Primary Insured's Employer:

Secondary Insurance Name: Insured's Date of Birth:

Secondary Policy Holder's Name: Policy Holder ID#:

Secondary Insured's Social Security #: Secondary Insured's Employer:

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:**

Revised September 2022