North Mississippi Medical Clinics Pediatric Patient Information Form

Name:	Last	First	Middle Initial	Preferred Name

Social Security #	**Date of Birth**	**Sex** Male Female

Mailing Address:	**Home Number:**
	Work Number:
City:	**Cell Number:**
State:	**Circle Preferred Contact Number Above**
Zip Code: **County**	**Email: (Responsible Party)**
Marital Status: Single Married Widowed Divorced	
Needs Interpreter: Yes No	**Written Language:**
Preferred Language:	**Race:**
Ethnicity: ☐ Not Hispanic, Latino/a, or Spanish ☐ Hispanic, Latino/a, or Spanish	**Visually Impaired:** Yes No
	Hearing Impaired: Yes No
	Mothers Maiden Name:

Employment Status: (circle) **Disabled** **Student** Full Time or Part Time **Not Employed** **Employed** Part Time or Full Time

Employer Name:

City **State/Zip** **Phone #**

Emergency Contact Name: **Relationship:** **Daytime Phone#**

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 to discuss your personal health information.*

Contact Name	Relationship	Daytime Phone	Notify On Admission
			Yes or No
			Yes or No
			Yes or No

Responsible Party Data				**Relationship to Patient**
(Primary Custodial Parent)	Last Name	First Name	MI	

Mailing Address:	**Social Security #**
City:	**Date of Birth**
State/Zip: **County**	**Home Phone:**
Employer:	**Cell Phone:**

Other Parent:	**Date of Birth:**
Last Name First Name MI	**Contact Number:**
Mailing Address:	
City: **State/Zip**	

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:	**Secondary Insurance:**
Policy Holder ID #:	**Policy Holder ID #:**

Complete below information if Policy Holder is NOT the patient

Policy Holder SSN:	**Policy Holder SSN:**
Policy Holder Date of Birth:	**Policy Holder Date of Birth:**
Policy Holder Name:	**Policy Holder Name:**

Patient/Guardian Signature: **Date:**

Revised 04/22