North Mississippi Medical Clinics 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		Marital Status:	M	S	W	D
Email Address:	Home Phone Number:					Cell Phone Number:			
Disabled ☐ Retired ☐ Employed ☐		Employer:				Work Phone:			
Emergency Contact:		Phone:							

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):

Name: Last First MI

Relation to Patient:

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

(form Revised March 2015) Form #975-008

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been given and received a copy of North Mississippi Medical Centers' hospitals and North Mississippi Medical Clinics' Notice of Privacy Practices. Your acknowledgment does not mean that you agree with our Notice of Privacy Practices or that you have read our Notice of Privacy Practices; it only means that you acknowledge receipt of a copy.

_____

Signature of Patient DATE

When patient is a minor or incompetent to sign Acknowledgment:

I hereby acknowledge that I have been given and received a copy of North Mississippi Medical Centers' hospitals and North Mississippi Medical Clinics' Notice of Privacy Practices on behalf of patient. Your acknowledgment does not mean that you agree with our Notice of Privacy Practices or that you have read our Notice of Privacy Practices; it only means that you acknowledge receipt of a copy.

_____

Signature of Patient DATE

_____

Relationship to Patient

When Patient or Authorized Person refuses to sign Acknowledgment:

Patient (or Authorized Person) was given a copy of Notice of Privacy Practices but refused to sign the Acknowledgment.

_____

NMMC Employee DATE