

North Mississippi Allergy & Asthma Center

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:		Cell Phone:			
☐ 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:		Cell Phone:					
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 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
Patient/Guardian Signature		Date: