North Mississippi Allergy & Asthma Center - 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:		Phone:	
Email Address:			

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 ☐	

PARENT'S INFORMATION:

MOTHER	SS # (required)	Date of Birth
Mother's Maiden Name		
Address (if different from Paient):		
Phone	Employment	Work #
FATHER	SS # (required)	Date of Birth
Address (if different from Paient):		
Phone	Employment	Work #

Parents Married? Yes/No If divorced, who has legal custody? (Please provide legal documentation)

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

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:	