NMPHC
1984 our 40th year 2024
NORTH MISSISSIPPI PRIMARY HEALTH CARE

NMPHC Patient Registration and Authorization Form

Patient First Name	Middle (Maiden) Name	Last Name	Name Patient Goes By

Mailing Address ☐ Unhomed Street	**Primary Phone**	**Preferences for Messaging:** ☐ Voice Call ☐ Do Not Contact ☐ Text Message ☐ Email
City State Zip	**Sexual Orientation** ☐ Lesbian, Gay, or Homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Something Else ☐ Don't know ☐ Choose not to disclose	Mother Maiden Name
E-Mail Address:		**Gender Identity** ☐ Male ☐ Gender Queer ☐ Female ☐ Other ☐ Transgender Male ☐ Transgender Female ☐ Choose not to Disclose
Date of Birth ***(MM/DD/YYYY)*** **SS Number**	**Marital Status:**	**How did you hear about us?** ☐ Family/Friends ☐ Advertisement ☐ Website ☐ Social Media ☐ Pharmacy
Patient Place of Employment	**Work Phone**	
Race:	**Ethnicity:**	**Are you a Veteran?** ☐ Yes ☐ No **Do you live in public housing?** ☐ Yes ☐ No

If Patient is a Minor

Parent or Guardian's Full Name	**Social Security Number**	**Primary Phone**
Mailing Address (City, State, Zip)	**Place of Employment and Phone Number**	

Responsible Party Information for Payment of Services

Full Name	**Social Security Number**	**Date of Birth**	**Contact Phone Number**
Mailing Address	**Place of Employment**		**Work Phone Number**

My Emergency Contact Person – (NO RELEASE of Health Information - Emergency Contact Only)

Full Name	Address (City, State, Zip)	Relationship	Contact Phone Number

Who can we contact about your health for assistance? (Blank means no one – not even a spouse-)

Full Name	Address (City, State, Zip)	Relationship	Contact Phone Number

1. **I have read and acknowledge NMPHC's Privacy Policy regarding my Protected Health Information (PHI) under HIPAA law and understand my contact person above can be contacted as necessary to assist me. I agree with the terms of the policy. I understand that I may retain a copy of the policy by asking for one and I have the right to amend or revoke my PHI.**
2. **I hereby authorize payment of services including the information necessary to process claims. I have submitted all the appropriate cards to be copied for my file (e.g., Medicare, Medicaid, and Insurance).**
3. **I hereby authorize and give permission to NMPHC and its employees to provide such medical, dental and/or behavioral treatment as may be deemed necessary for the patient named above.**

Patient/Guardian Signature _____ **Date** _____