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

NMPHC Patient Registration and Authorization Form

Patient Identification

Legal Last Name	Legal First Name	First Name Used	Middle Name, Suffix	Previous Name

Legal Sex ☐ Female ☐ Male	DOB	SSN	Mother's Maiden

Patient Contact

Address	Zip Code	City	State	Patient Email

Consent to Receive Automated Correspondence

Calls ☐ Yes ☐ No	Texts ☐ Yes ☐ No	Mobile Phone	Home Phone	Work Phone	Primary Phone ☐ Mobile ☐ Home ☐ Work

Patient Demographics

Language
- ☐ English
- ☐ Spanish
- ☐ Other _____
- ☐ Declined to answer

Marital Status
- ☐ Married ☐ Single
- ☐ Divorced ☐ Separated
- ☐ Widowed ☐ Partner
- ☐ Declined to answer

Race
- ☐ Asian
- ☐ Black / African American
- ☐ Mexican American
- ☐ White
- ☐ Native Hawaiian or Other
- ☐ Other _____
- ☐ Declined to answer

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to Answer

Sex
- ☐ Male ☐ Female
- ☐ Declined to answer

Sliding Fee Discount Program

Would patient like to participate in the Sliding Fee Discount Program? ☐ Yes, Participate ☐ No, Decline to Participate	Family Size _____ ☐ Declined	Income Total _____ ☐ Declined

Agricultural Worker ☐ Yes ☐ No ☐ Declined	Homeless Status ☐ Yes ☐ No ☐ Declined	School-Based Health Center Patient ☐ Yes ☐ No ☐ Declined	Veteran Status ☐ Yes ☐ No ☐ Declined	Public Housing Patient ☐ Yes ☐ No ☐ Declined

Billing Information

Insurance Name _____ **ID #**: _____

Policy Holder Name: _____ **Group #**: _____

Emergency Contact Information

Name	Relationship	Home Phone	Mobile Phone

Release of Information

Name	Relationship	Home Phone	Mobile Phone

Employment Information

Employer Name	Employee Phone	Guardian Last Name	Guardian First Name

Guarantor Information

Guarantor Last Name	Guarantor First Name	Middle Name, Suffix	Guarantor DOB

Guarantor Statement Mailing Address	Zip Code	City	State

☐ 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.

☐ 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).

☐ 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** _____