MISSISSIPPI Asthma & Allergy Clinic P.A.

Date: _____

PATIENT DEMOGRAPHICS FORM

Last Name _____ First Name _____ MI _____ Date of Birth ___-___-___ Age _____

Preferred Name _____ Gender _____ Social Security Number ___-___-___

Race: ☐ White ☐ African American ☐ American Indian ☐ Asian ☐ Hispanic-Latino ☐ Other:_____

Ethnicity: ☐ American ☐ Mexican ☐ Japanese ☐ Chinese ☐ Asian ☐ European ☐ Latino ☐ Other:_____

☐ English ☐ Spanish ☐ Other:_____ Preferred Language ☐ Married ☐ Single ☐ Widowed ☐ Other:_____ Marital Status

Patient's Home Address _____ City _____ State _____ Zip Code _____

Contact Preference (Cell/Work/Home) _____ Cell Phone (___)_____ Work Phone (___)_____ Home Phone (___)_____

Email Address _____ Occupation/Retired _____ Employer _____

Employer Address _____ City _____ State _____ Zip Code _____

~~~~~~~~~~~~~~~~~~~~ Spouse Information ~~~~~~~~~~~~~~~~~~~~

Full Name _____ Date of Birth ___-___-___ Age _____ Cell Phone Number (___)_____ SSN ___-___-___

Employer _____ Employer Address _____ City _____ State _____ Zip Code _____ Work Phone (___)_____

~~~~~~~~~~~~~~~~~~~~ Emergency Contact ~~~~~~~~~~~~~~~~~~~~

Name _____ Relationship _____ Cell Phone (___)_____ Work Phone (___)_____ Home Phone (___)_____

~~~~~~~~~~~~~~~~~~~~ If Patient is a Minor ~~~~~~~~~~~~~~~~~~~~

Mother's Full Name _____ Date of Birth ___-___-___ Phone Number (Cell or Home) (___)_____ SSN ___-___-___

Mother's Employer _____ Work Phone (___)_____ Home Address (if different from patient) _____

Father's Full Name _____ Date of Birth ___-___-___ Phone Number (Cell or Home) (___)_____ SSN ___-___-___

Father's Employer _____ Work Phone (___)_____ Home Address (if different from patient) _____

Please complete the other side of this form. Give all insurance cards to the receptionist to copy.

Date: _____

~~~~~~~~~~~~~~~~~~~~ Pharmacy Information ~~~~~~~~~~~~~~~~~~~~

Preferred Pharmacy	Street Address	City	State	Phone Number
_____	_____	_____	_____	(____)_____

~~~~~~~~~~~~~~~~~~~~ Physician Information ~~~~~~~~~~~~~~~~~~~~

Primary Care Physician	Street Address	City	State	Phone Number
_____	_____	_____	_____	(____)_____

Other Physician's Name & Specialty	Street Address	City	State	Phone Number
_____	_____	_____	_____	(____)_____

~~~~~~~~~~~~~~~~~~~~ Insurance Information ~~~~~~~~~~~~~~~~~~~~

(Please give insurance card to receptionist to copy)

Primary Insurance	Owner Name	Owner DOB
_____	_____	_____
_____	_____	_____
_____	_____	_____

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff of MS Asthma & Allergy Clinic, PA to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected healthcare information will not be disclose except in those situations described in the Notice of Privacy Practices of MS Asthma & Allergy Clinic, PA.

List name and relationship of person(s) who you wish to allow access (e.g. your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity	Relationship
_____	_____
_____	_____
_____	_____

I have been provided a summary of the Health Insurance Portability and Accountability Act of 1996 (HIPAA-Notice of Privacy Practices) and the revised HIPAA Mega Rule to read. I understand and consent to MS Asthma & Allergy Clinic, PA's use and disclosure of protected health information about myself for treatment, payment, and healthcare operations.

_____ Signature of Patient or Patient Representative

I have been provided a copy of the MSAAC Financial Policy to read. I understand that I, the patient or the patient representative, am/is responsible for payment of all charges for services rendered. I also acknowledge that nonpayment of my account may result in collections proceedings and dismissal from the practice.

_____ Signature of Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims, and I authorize the release of payment for medical benefits to MS Asthma & Allergy Clinic, PA..

_____ Signature of Patient or Patient Representative

I have been provided a Summary of the Formulary Benefits Data Consent Form. I consent for MS Asthma & Allergy Clinic, PA to obtain formulary information and information about other prescriptions prescribed by other providers.

_____ Signature of Patient or Patient Representative