



## NEW PATIENT REGISTRATION

Patient Name: First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Gender: \_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Marital Status: \_\_\_\_\_ U.S. Military/Veteran? \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
*street city state zip*

Phone Number(s): \_\_\_\_\_  
*home mobile work*

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Is the patient employed? \_\_\_\_\_ Is the patient a student? \_\_\_\_\_

Employer: \_\_\_\_\_ School: \_\_\_\_\_

Person Completing form if not patient: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Were you referred to MCAM? \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Provider : \_\_\_\_\_ Phone: \_\_\_\_\_

## MINORS ONLY - GUARANTOR INFORMATION

Mother/Guardian's Name: \_\_\_\_\_ Father/Guardian's Name: \_\_\_\_\_

Person responsible for Bill (guarantor): \_\_\_\_\_

SSN: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

## INSURANCE

### Primary Insurance

Insurance Company: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ SSN: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Subscriber Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Secondary Insurance

Insurance Company: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ SSN: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Subscriber Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PLEASE TURN OVER TO COMPLETE →



## Authorizations and Acknowledgements

Patient Name: \_\_\_\_\_  
First Middle Last

### Acknowledgement of Notice of Privacy Practices

Initial Here \_\_\_\_\_ I, the patient or authorized representative of the patient, acknowledge that a copy of the Notice of Privacy Practices was provided to me.

### General Consent to Treatment and Test

Initial Here \_\_\_\_\_ I, the patient or authorized representative of the patient, am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse or other health care professionals in this clinic. I also consent to any medical procedures, x-ray, laboratory tests, or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

### Release of Information

Initial Here \_\_\_\_\_ I, the patient or authorized representative of the patient, authorize the Mississippi Center for Advanced Medicine to release any medical information necessary to process payment of my claim.

### Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here \_\_\_\_\_ I, the patient or authorized representative of the patient, authorize payment directly to the Mississippi Center for Advanced Medicine for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible.

### Communications Regarding My Account

Initial Here \_\_\_\_\_ I, the patient or authorized representative of the patient, agree that the facility or any other collection or servicing agency or agencies retained by the facility to collect any money that I owe to the facility may contact me by telephone, text message, email, or letter.

I authorize release of my personal information including medical treatment, scheduling and billing information to the individuals listed below.

Name	Relationship

\_\_\_\_\_  
Signature of patient/parent/guardian/person authorized to represent the patient

\_\_\_\_\_  
Date

How you heard about us: \_\_\_\_\_