DeSoto Family Medical Center
Quality Care for Your Entire Family

PLEASE PRINT LEGIBLY

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City/State: _____ Zip: _____

Cell #: _____ Home #: _____ Work#: _____

Marital Status: _____ Sex: Male or Female (circle one) Race: _____ (optional)

Email: _____

Responsibility Party: _____ DOB: _____ SS#: _____

Address if different: _____ City/State: _____ Zip: _____

Employer Name: _____ Phone#: _____

Primary Insurance: Name: _____

Address: _____ City/State: _____ Zip: _____

Insured's Name: _____ DOB: _____ SS#: _____

Member ID#: _____ Group#: _____

Relationship to Patient: Self Child Spouse Other (circle one)

Secondary Insurance: Name: _____

Address: _____ City/State: _____ Zip: _____

Insured's Name: _____ DOB: _____ SS#: _____

Member ID#: _____ Group#: _____

Relationship to Patient: Self Child Spouse Other (circle one)

Emergency Contact: _____ Phone#: _____

Relationship to Patient: Parent Child Spouse Grandparent Friend Other (circle one)

Pharmacy Name: _____ Pharmacy Location: _____

By signing below I acknowledge and agree to the terms of the Financial Policy, DFMC Privacy Notice and it gives my permission to treat and file my insurance.

_____ _____

Patients or Guardian/Responsible Party ***Date***

75 Physicians Lane * Southaven, MS 38671
(662) 393-7722

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Permission to Share PHI Authorization Form

I, _____, do by my signature below give permission to share my personal medical information with the person(s) listed below.

I do ___, I do not ___ give my permission to leave relevant medical information on my answering machine or voice mail.

I understand this permission is valid until revoked. If I wish to revoke it, I must do so in writing.

_____	_____	_____
Patient's Signature	Date of Birth	Today's Date

Please print the information below:

_____	_____	_____
Name of Person to share info with	Their Date of Birth	Phone #
_____	_____	_____
Name of Person to Share info with	Their Date of Birth	Phone #