Mississippi Children's HEART CLINIC

NEW PATIENT INFORMATION

CHILD'S INFORMATION

Child's Full Name: _____ DOB: ____/____/____

Sex: ◯ Male ◯ Female Language: _____ Do you need a translator? ◯ Yes ◯ No

Social Security #: _____

Preferred Pharmacy: _____

Primary Care Provider: _____

Child Lives With: ◯ Both Parents ◯ Mother ◯ Father ◯ Other: _____

MOTHER'S INFORMATION

Responsible for Payment/Guarantor ☐ (initial) _____

Full Name: _____ DOB: ____/____/____

Social Security #: _____ Phone #: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

FATHER'S INFORMATION

Responsible for Payment/Guarantor ☐ (initial) _____

Full Name: _____ DOB: ____/____/____

Social Security #: _____ Phone #: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Name of Insured: _____ DOB: ____/____/____

Relationship to Patient: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Name of Insured: _____ DOB: ____/____/____

Relationship to Patient: _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Mississippi Children's Heart Clinic for all insurance benefits otherwise payable to me for services rendered. I certify that the information I have reported to Mississippi Children's Heart Clinic with regard to my insurance is correct. I also authorize the release of any necessary information, including medical information, if requested by my insurance company. I permit a copy of this authorization to be used in such instances. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment charges for treatment/services rendered.

Responsible Party or Patient (if over the age of 18): _____ **Date:** ____/____/____