Patient Forms

Basic Information

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** _____

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number** _____

Email _____ **Social Security Number** _____

Address Line 1 _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Marital Status _____ **Maiden Last** _____

Driver's License State _____ **Driver's License #** _____

Demographics

Sexual Orientation _____ **Gender Identity** _____

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify **Ethnicity** _____

Race _____ **Language** _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number** _____

Email _____

Address Line 1 _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ **Home** ◯ **Mobile** ◯ **Work** **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** _____

Policy ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Secondary Policy Holder _____

If you are not the secondary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** _____

Insurance ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us?

Uppal Medical Center, LLC
1727 East Union Street
Greenville, MS

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA requirements, Uppal Medical Center, LLC Medical Center is providing you with a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Mississippi law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of the entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse / neglect investigation.

In some instances, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another covered entity for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our Notice of Privacy Practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____
Patient Signature

_____
Patient Name (Please Print)

_____
Patient or Parent/Guardian Signature

_____
Relationship to Patient

Other adults authorized to bring minor patient for care:

_____

_____

_____

Uppal Medical Center, LLC
1727 East Union Street
Greenville, MS

Patient Consent & Authorization

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

Communication with laboratories or other specialists for any medical treatment, consultations, and educational purposes or for any other purpose deemed appropriate by Uppal Medical Center, LLC Medical Center.

_____
Patient Signature

_____
Patient Name (Please Print)

_____
Patient or Parent/Guardian Signature

_____
Date

For Office Use Only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement.

_____
_____
_____
_____

_____
Office Personnel Signature

_____
Office Personnel Name (Please Print)

_____
Date

Do you have Advanced Medical Directives?	YES	NO
Are you interested in information on Advanced Medical Directives?	YES	NO