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Patient Data Form

Last Name

First Name

Preferred Name

Middle Name

_____/_____/_____
Date of Birth

_____–_____ – _____
Social Security #

Address

Address *(cont.)*

ZIP Code

City

State

County *(Monroe, Itawamba, etc.)*

Gender: ❑ Male ❑ Female

(_____) _____ -_____ ❑ None
Home Phone

(_____) _____-_____ ❑ None
Mobile Phone Consent to: **CALL** ❑Y ❑N • **TEXT** ❑Y ❑N

(_____) _____-_____ ❑ None
Work Phone

Patient/Guardian Email Address ❑ No email ❑ Decline
*Email address is **required** to register for the **Patient Portal**. With a portal account, you can view your health information for each visit, including vitals, problem(s), diagnosis, lab results, & more. You can also securely communicate with your provider/nurse, request med refills, make appointments, view your account balance, & make payments.*

Contact Preference

❑ Mobile Phone ❑ Home Phone

❑ Work Phone ❑ Mail ❑ Patient Portal

Usual or Preferred Doctor/Pediatrician/Practitioner

Name _____

Phone _____

City/State _____/_____

Patient's Marital Status

❑ Single ❑ Married ❑ Divorced

❑ Separated ❑ Widowed ❑ Partner

Language

❑ English ❑ Non-English ❑ Decline

Race

❑ White ❑ Black ❑ Asian

❑ Other Pacific Islander ❑ Decline

Ethnicity

❑ Non-Hispanic/Latino ❑ Hispanic/Latino/Spanish

❑ Central American ❑ Cuban ❑ Mexican

❑ Dominican ❑ Latin American/Latin/Latino

❑ Puerto Rican ❑ South American ❑ Decline

Check All That Apply

Agricultural worker	❑Yes	❑No	❑Decline
Homeless	❑Yes	❑No	❑Decline
Veteran	❑Yes	❑No	❑Decline
Public housing	❑Yes	❑No	❑Decline

Siblings Attending Here ❑ *Not applicable*

Name	**Age**	**Grade**
Name	**Age**	**Grade**
Name	**Age**	**Grade**

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Preferred Pharmacy

Pharmacy Name

In What City? *(If pharmacy has multiple locations in the same city, include **city name** and **general location**.)*

How did you hear about Access Family Health?

❑ Online Ad ❑ Physician/Specialist
❑ Word of Mouth ❑ Hospital
❑ Another Patient ❑ Social Media
❑ Other: _____

How would you like your Patient Care Summary?

The Patient Care Summary is a general overview of your visit, including vitals, problem(s), diagnosis, meds, etc.

❑ Send to patient portal (online) ❑ Paper copy

Emergency Contact

First Name Last Name

_____–_____–_____

Phone (with area code)

Emergency contact's relationship to patient:

❑ Spouse ❑ Parent ❑ Child
❑ Sibling ❑ Friend ❑ Grandparent
❑ Guardian ❑ Other: _____

Next of Kin ❑ Same as emergency contact.

If not checked or none listed, emergency contact will be used.

Name: _____
Phone: _____–_____–_____
Their relationship to patient: _____

Mother's Maiden Name

_____

School

❑ Hatley ❑ Tremont ❑ Pontotoc City
❑ Smithville ❑ Nettleton ❑ Okolona Elem
❑ Hamilton ❑ N Pontotoc ❑ Okolona High
❑ S Pontotoc

Role

❑ Student ❑ Faculty/Staff

Grade ❑ Not a student/teacher

❑ PreK ❑ K ❑ 1st ❑ 2nd ❑ 3rd ❑ 4th ❑ 5th
❑ 6th ❑ 7th ❑ 8th ❑ 9th ❑ 10th ❑ 11th ❑ 12th

Guarantor

(Guarantor is who receives statements)

Patient's relationship to guarantor

❑ Self ❑ Spouse ❑ Child
❑ Grandparent ❑ Grandchild
❑ Nephew/Niece ❑ Foster Child
❑ Other ❑ Unknown

Guarantor

Last Name

First Name

__/__/__
Date of Birth

Mailing Address ❑ Same as patient

Address 1 *(physical/street address)*

Address 2 *(e.g., PO Box, Apt #, etc.)*

Zip City State

_____–_____ – _____
Social Security #

(_____) _____-_____
Phone #

Guarantor Email
❑ Same email as patient
❑ No guarantor email

RETURN this form to school

Insurance Information

INSURED'S INFORMATION: So we may file your insurance correctly, please make sure the receptionist has a copy of your **current** insurance card(s) **at each visit**. It is the **patient's responsibility** to make sure we have the correct insurance on file at the time of service. Thank you!	
Primary Insurance Name	**Insured's Date of Birth** / /
Primary Insured's SSN – –	**Policy Holder ID#**
Primary Policy Holder's Name	**Primary Insured's Employer**
Secondary Insurance Name	**Insured's Date of Birth** / /
Secondary Insured's SSN – –	**Policy Holder ID#**
Secondary Policy Holder's Name	**Secondary Insured's Employer**

Would you like to apply for financial assistance?

❑ **Yes** (Find out if you qualify using the steps below.)
❑ **No** (Simply **sign & date below**, return to the receptionist, and you're done.)

Access Assistance (Sliding Fee) Program

Income amounts based on 2021 Federal Poverty Level.

COLUMN A	COLUMN B
People Living in Your Home	Annual Household Income
❑ 1	❑ $25,760
❑ 2	❑ $34,840
❑ 3	❑ $43,920
❑ 4	❑ $53,000
❑ 5	❑ $62,080
❑ 6	❑ $71,160

Using the chart above:

Step 1: In Column A, check the number of people living in your home.
Step 2: In Column B, check the amount directly across from the number you checked in Column A.
Step 3: Check the box <u>below</u> that best represents your result.

❑ My annual household income is **greater than** the amount checked in Column B, so I do not qualify.
❑ My annual household income is **less than** the amount checked in Column B, and **I want to apply.**

_____ _____/_____/_____

Signature of Patient • Parent • Guardian Date