**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

**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 #

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## Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical records. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medication in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

**I give my permission to allow Desoto Family Medical to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**

____________________________________

Print Patients Name

____________________________________ _______________________________

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving Desoto Family Medical Center permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.