Patient Registration Form

Patient Information

Full Name: _____ Social Security Number: _____-_____-_____

Date of Birth: ____/____/____Sex: _____ Marital Status: _____ Race: _____

Address: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Work Email: _____

Employer: _____Retired? ☐ Yes ☐ No Disabled? ☐ Yes ☐No

Is this a work-related injury? ☐ Yes ☐ No

Spouse Information (if applicable)

Spouse Name: _____Date of Birth: _____/_____/_____

Social Security Number: _____-____-_____Employer: _____Phone: _____

Responsible Party (Complete if someone other than the patient is responsible for payment.)

Guarantor's Name: _____Date of Birth: ____/____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____

Address (if different from patient) _____

Primary Phone: _____ Social Security Number: _____-____-____

Emergency Contact (other than spouse)

Name: _____Relationship: _____ Phone: _____

Insurance Information (Please provide your insurance card at your first visit.)

Primary Insurance Company: _____ Member ID #: _____Group #: _____

Address: _____

Subscriber Name: _____Subscriber Date of Birth: ____/___/____Relationship: _____

Secondary (if applicable): _____Member ID #: _____Group #: _____

Address: _____

Subscriber Name: _____Subscriber Date of Birth: ____/___/____Relationship: _____

Primary Care Provider Information

Primary Care Provider Name: _____

Practice Name: _____Phone Number: _____

Referring Provider Information

Referring Provider Name: _____ Phone Number: _____

Pharmacy Information

Preferred Pharmacy Name: _____Location: _____Phone: _____

Patient Acknowledgment

I confirm that the information provided on this form is accurate and complete to the best of my knowledge. I understand that providing accurate information helps my healthcare team provide appropriate care.

Patient/Guarantor Signature: _____Date: _____

Sharon Hong, M.D. | Teresa Crout, M.D.
Mississippi Rheumatology and Osteoporosis Center, PLLC
2550 Flowood Drive, Suite 300, Flowood, MS 39232
Phone: (601) 420-0034 Fax: (601) 420-5482

HIPAA Authorization for Release of Health Information

I authorize Mississippi Rheumatology & Osteoporosis Center, PLLC to discuss my protected health information (PHI) with the individuals listed below. This may include information regarding my medical care, appointments, test results, medications, treatment plans, and billing matters.

Authorized Individual #1

Name: _____Relationship to Patient: _____

Phone Number: _____

Authorized Individual #2

Name: _____Relationship to Patient: _____

Phone Number: _____

☐ I do not authorize Mississippi Rheumatology & Osteoporosis Center, PLLC to discuss my health information with anyone other than myself.

I understand that:

- I may revoke this authorization at any time by providing written notice to Mississippi Rheumatology & Osteoporosis Center, PLLC.
- I am not required to sign this authorization as a condition of receiving treatment.
- Information disclosed under this authorization may no longer be protected by federal privacy regulations once released to the authorized individual.

Patient Acknowledgment and Signature

I acknowledge that I have read and understand this HIPAA Authorization for Release of Health Information form. I understand that I am authorizing Mississippi Rheumatology & Osteoporosis Center, PLLC to discuss my protected health information with the individuals I have listed.

Patient/Authorized Representative Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____Date: _____

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