John C. Longest Student Health Center
360 Hardy Rd. Mississippi State, MS
Phone (662)-325-5895
Fax (662)-325-8888

Patient Demographic Information

Print Name: _____ Date of Birth: _____/_____/_____

MSU ID: _____ NET ID: _____ Social Security #:_____

Address: _____
Street City State Zip Code

Email address:_____

Cell Phone: (_____) _____ Home Phone: (_____) _____

Circle One: Male Female Marital Status: Single Married Divorced

Place of Employment (if not a student): _____

Insurance

Check Here If No Insurance: _____ Insurance Company Name:_____

Mailing Address: _____
(on back of card) Street/P.O. Box City State Zip Code

Insurance ID Number: _____ Group Number: _____

Insurance Policy Holder (Person Who Owns Policy)

Name: _____ Circle One: Male Female

Address: _____
Street City State Zip Code

Date of Birth: _____/_____/_____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Relationship to Patient: Self Spouse Parent Employer/School _____

Emergency Contact

Last Name: _____ First Name: _____ Relationship: _____

Cell Phone: (_____) _____ Work Phone: (_____) _____

John C. Longest Student Health Center
P.O. Box 6338
Mississippi State, MS 39762
Phone 662-325-2431 Fax 662-325-8888

Consent to Treat, Release of Information, Authorization to Pay Physician

I request and give permission to my SHC provider to provide and perform such medical care, test, procedures, drugs, other services, and supplies are considered necessary or beneficial by my SHC provider for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. I authorize the release of any medical or other information necessary to process this claim and as necessary to collect debts owned by me to the SHC. I also request payment of government benefits either to myself or to the party who accepts assignment below. I understand that charges are due at the time service is rendered. I authorize any insurance benefits be paid to the physician.

Print Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices Receipt

I acknowledge that I was provided (see following pages) with the HIPAA Notice of Privacy Practices revision August 20, 2019 of Longest Student Health Center. Longest Student Health Center Privacy Official, Jennifer Williams 662-325-2431.

Patient Signature: _____ Date: _____

Personal Representative of the Patient (if applicable)

Print Name: _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____

For Practice Use Only
Signature of Practice Employee: _____ Date: _____
Revision 10/16/2019