Harmony House Calls & Medical Services
7 Lakeland Circle Ste 500 Jackson MS 39216 601.300.3935 office

New Patient Registration Form

This Form may be faxed to 769.241.0003

Patient Information

Last Name: _____ First Name: _____ MI: _____

Sex: M / F DOB: _____/_____/_____ Soc. Sec. #: _____-_____-_____

Community name (if not at home): _____ Apt or Room #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home (_____) _____-_____ Cell (_____) _____-_____ E-mail:_____

Emergency Contact Person

Last Name: _____ First Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home (____) _____-_____ Cell (____) _____-_____ Work (____) _____-_____ Ext _____

E-mail Address: _____ Preferred method of contact: _____

Is this person the Healthcare Power of Attorney (POA)? Y / N (If yes, please attach a copy of the POA form)

Secondary Contact Person:

Last Name: _____ First Name: _____ Relationship to patient: _____

Phone: Home (____) _____-_____ Cell (____) _____-_____ Work (____) _____-_____ Ext _____

E-mail Address: _____ Preferred method of contact: _____

Is this person the Healthcare Power of Attorney (POA)? Y / N (If yes, please attach a copy of the POA form)

Primary Insurance Policy - Name of Insurance:_____

Policy, Subscriber, etc. #: _____ Grp #:_____

Medicare Supplement/Medicaid - Name of Insurance: _____

Subscriber Name: _____ Medicaid ID or Policy Number: _____

Credit Card Information ****(complete if you would like to have on file for your visit copays)

Credit Card Type: _____ #_____ Exp.:_____/_____

Card Holder's Name: _____ CVC2 (3 digit code, Amex is 4 digits): _____

Cardholder's Address: _____

Required Medical Information

Preferred Pharmacy: _____ Preferred Hospital: _____

Allergies: _____

Smoking status: _____ Alcohol Use: _____

Previous Primary Care Physician, Specialists, Hospital Visits: _____

_____

Medications- name/dosage/frequency (attach or list):_____

_____