

MCHD CLIENT INFORMATION FORM

Adult responsible for payment

Name _____ Gender _____ Race _____ Ethnicity _____
(First) (MI) (Last)

Address _____ City _____ State _____ Zip _____

DOB _____ - _____ - _____ Main Phone # _____ SSN# _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Maiden Name: _____

Education Level Completed: Less than 12 years of High School _____ HS Diploma _____ GED _____ College _____

Employment: Full Time _____ Part Time _____ Seasonal _____ Unemployed _____ 2yr or 4yr

Listing of Children under the age of 18

_____	DOB _____	Gender _____	Race _____	Age _____
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_____	DOB _____	Gender _____	Race _____	Age _____
_____	DOB _____	Gender _____	Race _____	Age _____
_____	DOB _____	Gender _____	Race _____	Age _____
_____	DOB _____	Gender _____	Race _____	Age _____

HIPAA Waiver

Because the Marshall County Health Department is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, your immunizations, health history, prescriptions and any other information contained in your medical records with us. Please list below any person or agencies that we have your permission to release your medical information and the medical information of the above family members to, if requested.

Father _____	Mother _____
Spouse _____	School _____
Siblings _____	Daycare _____
Doctor/Clinic _____	Other _____

I acknowledge that I have received or have been offered a copy of the Marshall County Health Department's Notice of Privacy Practices with a revision date of February 28, 2016. I certify that the above information is correct to the best of my knowledge. I understand the Adult listed above will be responsible for any services provided in which the insurance does not cover.

IF WE ARE FILING INSURANCE:

Insured or authorized person's signature: I authorize payment of medical benefits to Marshall County Health Department. I also authorize the release of any medical or other personal information necessary to process this claim.

How many people currently reside in your home? _____

What is your family income (pick one)? (yearly) _____ (monthly) _____ (weekly) _____

Authorized Signature _____ Date _____