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 Primary School _____HS Diploma ____GED _____ College
Employment: ____Full Time _____ Part Time _____Seasonal _____Unemployed 1yr, 2yr or 4yr

Listing of Children under the age of 18

_____ _____ _____ **DOB**_____-_____-_____ **Gender**_____ **Race**____ **Age**___
_____ _____ _____ **DOB**_____-_____-_____ **Gender**_____ **Race**____ **Age**___
_____ _____ _____ **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)_____

Email address _____

Authorized Signature _____ **Date**_____

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