Natchez
After Hours Clinic
46 S. Sgt. Prentiss Dr., Suite 101 601-442-1900
Natchez, MS 39120 Fax 601-442-1908

Is this visit the result of an accident? Y N
Is this a result of a car accident? Y N
Did this occur at work? Y N
Patient's primary care Physician ___________________________
HOW DID YOU HEAR ABOUT US? __RADIO__BILLBOARD__PAPER__WORD OF MOUTH

___________________________________ ____________________________________
Patient Name (first, middle, last) Address **and** P. O. Box / APT. #

Patient gender: M F
____
City State Zip
Place of employment_________________________
Dr. Lic.#_________________________

Patient Relation: (your…) SELF SPOUSE CHILD OTHER

HOME#____________________ **(List at least two phone #s)** Marital Status S M W D

WORK#___________________ Patient Birth Date _________________
(month, day, yr)
CELL #____________________ ________/_____/_________
Patient Social Security #

***COMPLETE RESPONSIBLE PARTY SECTION IF PATIENT IS MINOR OR IF THE SUBSCRIBER OF INSURANCE IS DIFFERENT FROM THE PATIENT.**

Name of R.P____________________________ ________________________________
(first, middle, last) (street #/ apt. #/ P.O. Box)

R.P Gender: M F Marital Status S M W D ________________________________
City State Zip
HOME #__________________

WORK#___________________ CO. NAME______________________ R. P's Birth Date_____________

CELL#____________________ ___________/______/__________
RP's social security#

**** REQUIRED TO COMPLETE IF CARD NOT AVAILABLE**

Primary Insurance________________________ Secondary (if applies)_____________________

Name of Cardholder_________________________ ID#_______________ group name/#___________

I consent to treatment for myself or minor/child. I understand that examination and/or medical treatment I receive is NOT intended to replace complete medical care by my primary care physician. I am aware that I will be responsible for co-pmt or full payment at time of service. Any pre-certification requirement that my insurance requires is my responsibility to make. Furthermore, I allow Natchez After Hours to release to my insurance treatment and billing information, as requested, to process my claim. I allow Natchez After Hours to accept assigned payments made by my insurance co. on my behalf. I understand that my lack of payment or if my insurance denies payment, I am responsible for payment in full for services rendered (failure to pay may result in collection proceeding). In addition, I authorize Natchez After Hours to release to my primary care physician or specialty referral, any and all information related to my treatment at this clinic.

X______________________________ _______________
Patient Signature or Parent of Minor Date PLEASE SIGN THE BACK ALSO