

VIP MidSouth, LLC Registration Form

Today's Date: _____

Patient Account # (office use only): _____

Patient Information									
Patient Last Name:			First:			Middle:			I prefer to be called:
Date of Birth:		Gender:		Male Female	SS#:		Primary Language(required):		
Race: (Choose One)	American Indian/Alaskan	Asian Declined	African American/Black	Native Hawaiian/Pacific Islander	White Other	Ethnicity: (Choose One)	Hispanic/Latino	Declined	Not Hispanic/Latino Unknown
Address:				City:			State:		Zip:
Home Phone:			Work Phone:			Cell Phone:			
Primary Pharmacy:		Email Address:			Place of Birth (hospital):		Name at Birth:		
Mother's Information									
Name:					Date of Birth:		SS#:		
Address: (If different than patient)				City:		State:		Zip:	
Home Phone:			Work Phone:			Cell Phone:			
Employer:			Are you the insurance carrier:			Yes	If yes is coverage:		No
						No	Primary	Secondary	
Insurance Name:			Insurance Effective Date:		Should you receive the statement for this account:		Yes	No	
Father's Information									
Name:					Date of Birth:		SS#:		
Address: (If different than patient)				City:		State:		Zip:	
Home Phone:			Work Phone:			Cell Phone:			
Employer:			Are you the insurance carrier:			Yes	If yes is coverage:		No
						No	Primary	Secondary	
Insurance Name:			Insurance Effective Date:		Should you receive the statement for this account:		Yes	No	
Emergency Contacts									
Name:			Phone #:			Relationship to patient:			
Name:			Phone #:			Relationship to Patient:			
Patient's Siblings									
Name:			DOB:			Are they a current patient?			
Name:			DOB:			Are they a current patient?			

Consent for Treatment

This certifies that I, the parent/legal guardian, request treatment of our minor child by the physicians and/or staff of VIP MidSouth, LLC. Authorization is hereby granted for such treatment.

Parent/Legal Guardian Signature: _____ Witness Signature: _____
Date: _____