Speech & Hearing Center of the Mid-South
dba Memphis Oral School for the Deaf
7901 Poplar Avenue
Germantown, TN 38138
901-758-2228 901-531-6735 fax

MEDICAL VITAL INFORMATION

SCHOOL YEAR _____

PATIENT / CHILD INFORMATION

Child's Name _____ (First) (Initial) (Last)

Address _____ (Street) (City) (State) (Zip) (County)

DOB _____ Age _____ Sex _____ Race _____ Nickname _____

Primary Care Physician _____ Phone _____

Clinic/Address _____ (Street) (City) (State) (Zip)

PARENT / GUARDIAN INFORMATION

Mother's Name _____ (First) (Initial) (Last) DOB _____

Address _____ (if other than child's) (Street) (City) (State) (Zip)

Cell # _____ Email _____

Employer _____ Work # _____

Father's Name _____ (First) (Initial) (Last) DOB _____

Address _____ (if other than child's) (Street) (City) (State) (Zip)

Cell # _____ Email _____

Employer _____ Work # _____

PREFERRED METHOD OF CONTACT WITH PARENT/GUARDIAN

Email: ☐ Yes ☐ No Voice Mail: ☐ Yes ☐ No Text Msg: ☐ Yes ☐ No

Email _____ Phone _____ Phone _____

PATIENT / CHILD'S INSURANCE INFORMATION

Primary Insurance _____ Member ID _____ Group _____

Insured's Name _____ DOB _____

Secondary Insurance _____ Member/ID _____ Group _____

Insured's Name _____ DOB _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received and reviewed a copy of the Notice of Privacy Practices for Speech & Hearing Center of the Mid-South, dba Memphis Oral School for the Deaf.

_____ _____ _____

Patient /Child's Name (print) **Parent / Guardian Signature** **Date**

ACCEPTANCE OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION & CONSENT

I authorize Speech & Hearing Center of the Mid-South, dba Memphis Oral School for the Deaf, to provide evaluations and/or treatment, release patient's information to the insurance company, and I authorize the direct payment of any medical benefits from the insurance company for services rendered. I understand and agree that charges not covered by my insurance company, as well as co-payments, co-insurance and deductibles are my responsibility.

_____ _____ _____

Patient/Child's Name (print) **Parent / Guardian Signature** **Date**