

**John C. Longest Student Health Center**  
**360 Hardy Rd. Mississippi State, MS**  
**Phone (662)-325-5895**  
**Fax (662)-325-8888**

**Patient Demographic Information**

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

MSU ID: \_\_\_\_\_ NET ID: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Email address: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Circle One: Male Female Marital Status: Single Married Divorced

Place of Employment (if not a student): \_\_\_\_\_

**Insurance**

Check Here If No Insurance: \_\_\_\_\_ Insurance Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(on back of card) Street/P.O. Box City State Zip Code

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Insurance Policy Holder (Person Who Owns Policy)**

Name: \_\_\_\_\_ Circle One: Male Female

Address: \_\_\_\_\_  
Street City State Zip Code

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Relationship to Patient: Self Spouse Parent Employer/School \_\_\_\_\_

**Emergency Contact**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

**John C. Longest Student Health Center  
P.O. Box 6338  
Mississippi State, MS 39762  
Phone 662-325-2431 Fax 662-325-8888**

**Consent to Treat, Release of Information, Authorization to Pay Physician**

I request and give permission to my SHC provider to provide and perform such medical care, test, procedures, drugs, other services, and supplies are considered necessary or beneficial by my SHC provider for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. I authorize the release of any medical or other information necessary to process this claim and as necessary to collect debts owned by me to the SHC. I also request payment of government benefits either to myself or to the party who accepts assignment below. I understand that charges are due at the time service is rendered. I authorize any insurance benefits be paid to the physician.

**Print Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice of Privacy Practices Receipt**

I acknowledge that I was provided (see following pages) with the HIPAA Notice of Privacy Practices revision August 20, 2019 of Longest Student Health Center. Longest Student Health Center Privacy Official, Jennifer Williams 662-325-2431.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Personal Representative of the Patient (if applicable)**

Print Name: \_\_\_\_\_

Signature of Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

For Practice Use Only

Signature of Practice Employee: \_\_\_\_\_ Date: \_\_\_\_\_