DEXTER
COMMUNITY CARE CENTER

Dear New Patient,

Thank you for choosing Dexter Community Care Center!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐ Patient Assessment ☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

We look forward to meeting you. If you have any questions, please let us know!

Hollie Hughes, FNP-BC
1523 West Business Hwy 60, Suite 1
Dexter MO 63841
(573) 614-5762
www.missouridelta.com

MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI

PATIENT INFORMATION
(to be completed by patient)

Date: _____

Name: First _____ Middle _____ Last _____

Date of Birth	Age	Sex	Marital Status	Race	Religion
_____	_____	_____	_____	_____	_____

Social Security Number _____ Maiden/Other Name _____ Family Doctor _____

Patient Address _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Email Address _____

Patient Employer _____

Address: _____

City/State/Zip _____ Phone _____

Preferred Pharmacy _____

Next of Kin

Spouse/Father/Mother Name _____ D.O.B. _____

(Spouse or Parent if Patient is under 18 years of age)

S.S.N.# _____ Cell Phone Number _____

Address if different from above _____

Spouse/Parent Employer _____

Address _____

City/State/Zip _____ Phone _____

Closest Relative NOT Living With You

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Person to Notify (other than Next of Kin)

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: _____

Date:_____

□ Patient was unable /unwilling to sign acknowledgment.

Reason: _____

Staff initials: _____

Date: _____

Time: _____

Below is a list of people that may receive full disclosure of my medical information:

_____

_____

_____

Copy of Notice was included in patient's Admission Information Packet