Patient Information Sheet

Patient Information

Legal Name _____ Preferred Name _____ Date of Birth # _____
Last *First* *Middle*

Sex: M F Social Security # _____ Other Known Name(s) _____
Please list names used in the past 24 months.

Mailing Address _____ City _____ State _____ Zip _____

Home Phone □ _____ Work Phone □ _____ Mobile Phone □ _____

Email address _____

Primary Care Physician Name _____ Location _____ Office Phone _____
City, State

Emergency Contact: Person to contact in case of emergency.
If Patient is a minor, list a person to contact regarding medical information.

Name _____ Hm Ph _____ Mobile _____ Relationship _____

Patient Employment Status *(circle one)* Disabled | Full Time | Part Time | Not Employed | Self Employed | On Active Military Duty | Retired | Student – Full Time | Student – Part Time | Unknown

Employer _____ Employer Phone _____ Employer Fax _____

Employer Address _____ City _____ State _____ Zip _____

Marital Status: *(circle one)*
Married
Divorced
Single
Widowed
Other_____

Language: *(circle one)*
English
Spanish
Other _____

Hearing Impaired Patients-Interpreter Needed: *(circle one)*
No
Yes

Ethnicity: *(circle one)*
Hispanic or Latino
Not Hispanic or Latino
Unknown
Decline to Answer

Race: *(circle one)*
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian
White or Caucasian
Decline to Answer
Other_____

Responsible Party Information (*Guarantor*)

□ The Responsible Party (Guarantor) for the account is the same as the patient above.

Complete the following if the patient is under 18 years of age and/or the Responsible Party is someone other than the patient.

Legal Name _____ Preferred Name _____ Date of Birth # _____
Last *First* *Middle*

Sex: M F Social Security # _____ Other Known Name(s) _____
Please list names used in the past 24 months.

Mailing Address _____ City _____ State _____ Zip _____

Home Phone □ _____ Work Phone □ _____ Mobile Phone □ _____
Please mark the box (□) next to the phone number you wish to use as your primary contact number.

Relationship to Patient _____ **Employment Status** *(circle one)* Disabled | Full Time | Part Time | Not Employed | Self Employed | On Active Military Duty | Retired | Student – Full Time | Student – Part Time | Unknown

Employer _____ Employer Phone _____ Employer Fax _____

Employer Address _____ City _____ State _____ Zip _____

Policy Holder Information (Subscriber) *Updated 01/14/2020*

□ The Patient is the Policy Holder of the Insurance.

□ The Responsible Party (Guarantor) for the account is the Policy Holder of the Insurance.

Policy Holder Name on Card _____ **Covered Through** *(circle one)* Current Employer | Retirement | COBRA/Cont of Benefits | Other

Complete the following if the Policy Holder for the insurance is someone other than the patient or the responsible party on the reverse side.

Legal Name _____ Preferred Name _____ Date of Birth # _____
Last *First* *Middle*

Sex: M F Social Security # _____ Other Known Name(s) _____
Please list names used in the past 24 months.

Mailing Address _____ City _____ State _____ Zip _____

Home Phone □ _____ Work Phone □ _____ Mobile Phone □ _____
Please mark the box (□) next to the phone number you wish to use as your primary contact number.

Relationship to Patient _____ **Employment Status** *(circle one)* Disabled | Full Time | Part Time | Not Employed | Self Employed | On Active Military Duty | Retired | Student – Full Time | Student – Part Time | Unknown

Employer _____ Employer Phone _____ Employer Fax _____

Employer Address _____ City _____ State _____ Zip _____

Patient Insurance Information

Primary Coverage

Insurance Company _____

Ins Address _____

City _____ State _____ Zip _____

Phone _____ Effective Date _____

Policy Holder _____ Relation to Patient _____

Ins ID # _____ Group # _____

Patient Name on Card _____

Covered Through *(circle one)* Current Employer | Retirement | Other COBRA/Cont of Benefits

Secondary/Supplemental Coverage

Insurance Company _____

Ins Address _____

City _____ State _____ Zip _____

Phone _____ Effective Date _____

Policy Holder _____ Relation to Patient _____

Ins ID # _____ Group # _____

Patient Name on Card _____

Covered Through *(circle one)* Current Employer | Retirement | Other COBRA/Cont of Benefits

Patient / Guarantor Disclosures

By initialing next to each item below and signing and dating the bottom of this form, I agree to the following:

Consent to Treatment

_____ I consent to and authorize treatment by The Baton Rouge Clinic.

HIPAA Acknowledgement

_____ I acknowledge that I have received a copy of the 'Notice of Privacy Practices'.

Authorization and Assignment

_____ I authorize The Baton Rouge Clinic to release medical information that may be necessary to request claim reimbursement from insurance companies to whom claims may be submitted. I also assign claim payments including major medical benefits to be made payable to The Baton Rouge Clinic. I understand The Baton Rouge Clinic will refund to me any overpayment upon request, regardless of insurance. This authorization and assignment may be revoked by me at any time by a written notice.

Financial Responsibility

_____ I understand I am responsible for co-payment and deductible amounts at the time service is rendered as well as any amount not covered by insurance.

Notifications

_____ I consent to receiving automated calls, text messages, and/or email notifications to the contact number and email address provided for appointment reminders and other notifications.

Note: Email notifications can be set up in the 'Preferences' section of your MyChart account.

Signed _____ Date _____