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 06/22/2022

□ 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	Secondary/Supplemental Coverage
Insurance Company________________________________	Insurance Company ____________________________________
Ins Address____	Ins Address ____
City________________________ State__________ Zip_____________	City___________________________ State__________ Zip_____________
Phone_____________________ Effective Date___________________	Phone_________________________ Effective Date _________________
Policy Holder__________________ Relation to Patient_____________	Policy Holder____________________ Relation to Patient ____________
Ins ID #____________________________ Group #_________________	Ins ID #______________________________ Group # ________________
Patient Name on Card_______________________________________	Patient Name on Card ____
Covered Through *(circle one)* Current Employer | Retirement | Other COBRA/Cont of Benefits	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 ______________________________________