



### 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 09/17/2024

- 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 _____		City _____		State _____	
Zip _____		Effective Date _____		Zip _____		Effective Date _____	
Phone _____		Rel. to Patient _____		Phone _____		Rel. to Patient _____	
Policy Holder _____		Group # _____		Policy Holder _____		Group # _____	
Ins. ID # _____		Patient Name on Card _____		Ins. ID # _____		Patient Name on Card _____	
Covered Through <i>(circle one)</i> _____		Current Employer   Retirement   Other COBRA/Cont. of Benefits		Covered Through <i>(circle one)</i> _____		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:

\_\_\_\_\_ I consent to and authorize treatment by Affinity Health Group – A Division of The Baton Rouge Clinic, AMC hereinafter referred to as “The Baton Rouge Clinic.”

\_\_\_\_\_ I acknowledge that I have received a copy of the ‘Notice of Privacy Practices’.

\_\_\_\_\_ 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.

\_\_\_\_\_ I authorize The Baton Rouge Clinic to access and obtain my prior health information from my previous patient record.

\_\_\_\_\_ 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.

\_\_\_\_\_ 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.*

Signature \_\_\_\_\_ Date \_\_\_\_\_