Updated 09/18/2025

# 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 an emergency.**
***If Patient is a minor, list a person to contact regarding medical information.**

Name _____ Mobile Phone _____ 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*)

□ The Patient is the Policy Holder of the Insurance.
□ The Responsible Party (*Guarantor*) for the account is the same as the patient above.

**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 _____ |
| Insurance Address _____ | Insurance Address _____ |
| City _____ State _____ Zip _____ | City _____ State _____ Zip _____ |
| Phone _____ Effective Date _____ | Phone _____ Effective Date _____ |
| Policy Holder _____ Rel. to Patient _____ | Policy Holder _____ Rel. 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 each item below and signing at the bottom, I confirm the information above is correct and agree to the following:

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

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

_____ I authorize The Baton Rouge Clinic, AMC 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, AMC. 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 medical record.

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

_____ I understand that my provider may use a secure, HIPAA-compliant system to record and store information. They may use a phone or microphone to transcribe our conversation for my medical record. All information is safely encrypted and stored for 30 days before being deleted.

_____ 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 _____