



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 _____

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 _____

Hearing Impaired Patients-

Interpreter Needed: (circle one)

No
Yes

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 11/13/2023

- ☐ 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 _____		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 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 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 *Aprima* 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 _____