

PATIENT INFORMATION SHEET

Patient Information -----

Patient Employer Info: (Fill in only if patient is employed)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Sex \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
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Additional Patient Information  
 1.Spouse's Name \_\_\_\_\_  
 2.Name of Nearest Relative Not Living With You \_\_\_\_\_  
 3.Phone Number of Nearest Relative \_\_\_\_\_

Guarantor Info:--(WHO IS RESPONSIBLE for any portion of bill not pd. by ins.)

Guarantor's Employer Info:

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Guarantor S.S. # \_\_\_\_\_ Guarantor Date of Birth \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Cell Number \_\_\_\_\_

Insurance Info:

Primary Insurance

Secondary Insurance

Third Insurance

Name of Insurance \_\_\_\_\_  
 Address to Mail Claim \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Certificate Number \_\_\_\_\_

Name of Insurance \_\_\_\_\_  
 Address to Mail Claim \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Certificate Number \_\_\_\_\_

Name of Insurance \_\_\_\_\_  
 Address to Mail Claim \_\_\_\_\_  
 Policy Holder Name \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Certificate Number \_\_\_\_\_

Group # \_\_\_\_\_ Member # \_\_\_\_\_  
 Social Security Number of INSURED \_\_\_\_\_  
 DOB \_\_\_\_\_  
 Male \_\_\_\_\_ Female \_\_\_\_\_

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 Social Security Number of INSURED \_\_\_\_\_  
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 Social Security Number of INSURED \_\_\_\_\_  
 DOB \_\_\_\_\_  
 Male \_\_\_\_\_ Female \_\_\_\_\_

Insurance Authorization and Assignment

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I further assign to the physician or supplier of services for myself and/or dependents any and all rights to penalties and/or attorney's fees under Louisiana law, including La. R.S. 22:657, resulting from my insurance carrier's or managed care plan's failure to timely pay any claims for medical benefits. I understand I am responsible for any deductibles, co-insurances/or amounts for services not covered by the insurance carrier. If I am a participant in a managed care plan, I also authorize the audit of my chart by that plan.

Date \_\_\_\_\_

Signature \_\_\_\_\_

MEDICAL INFORMATION

REFERRED BY \_\_\_\_\_

What is your main complaint? \_\_\_\_\_

How long have you been suffering with this? \_\_\_\_\_

Are you allergic to any medication? \_\_\_\_\_