Patient Information Sheet

Patient Information

MRN (Epic) ___________________

Name ____ Social Security # ________________ Sex: M F
Last First Middle

Date of Birth ______________ other known name(s) ____

Mailing Address ____________________________________ ____________________ _______________ ________
City State Zip

Parish _____________________ Country _____________________ permanent address temporary address

Home phone ______________________ Work phone ___________________ Mobile phone ____________________

Email address _______________________________________ Language ____________________________________

Person outside of household to contact in case of emergency or in case we must reschedule an appointment for you.

Name ____ Phone #'s ___________________________ Relationship ______________

Marital Status: (circle one)
Married Divorced
Legally Separated Single
Widowed Significant Other
Unknown Other

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Unknown
Patient Refused

Race: (circle one)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or Caucasian
Unknown Other Patient Refused

I acknowledge that I have received a NOTICE OF PRIVACY PRACTICES
Initialed by:______________
Date:___________

Primary Care Physician____

Responsible Party Information (Guarantor)

Name ____ Social Security # ________________ Sex: M F
Last First Middle

Date of Birth _______________ other known name(s) ____

Mailing Address ____________________________________ ____________________ _______________ ________
City State Zip

Parish _____________________ Country _____________________ Relationship to patient _______________________

Home phone ______________________ Work phone __________________ Mobile phone ________________________

Employer ____

Employer address _______________________________ _____________________ _________________ ___________
City State Zip

Employer phone ________________________ Employer fax _________________________

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

Subscriber Information (if different from Guarantor)

Name ____ Social Security # _______________ Sex: M F
Last First Middle

Date of Birth _______________ other known name(s) ____

Mailing Address __________________________________ ___________________ _______________ _______
City State Zip

Parish ____________________ Country ____________________ Relationship to patient____________________

Home phone _____________________ Work phone _________________ Mobile phone _______________________

Employer ____

Employer address ______________________________ ____________________ ________________ ___________
City State Zip

Employer phone _______________________ Employer fax ________________________

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

Insurance Information

(Primary Coverage)

Insurance Company ____________________________

Ins Address __________________________________

City _____________________ State ______________

Zip ___________ Phone _________________________

Relationship to Patient __________________________

Insurance ID # ________________________________

Effective Date ________________________________

Group # _____________________________________

Name on Card ________________________________

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other _________________

Employer Size: (circle one) 1-19 employees
20-99 employees
100+ employees

(Secondary/Supplemental Coverage)

Insurance Company ___________________________

Insurance Address ____________________________

City ______________________ State ____________

Zip __________ Phone _________________________

Relationship to Patient _________________________

Insurance ID# _______________________________

Effective Date ________________________________

Group # _____________________________________

Name on Card _______________________________

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other _________________

Employer Size: (circle one) 1-19 employees
20-99 employees
100+employees

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.

Signed____ Date ___________________________