LSU Health
Healthcare Network

PATIENT INFORMATION

Name (Last, First, Middle Initial):

Salutation:
☐ Mr. ☐ Miss
☐ Mrs. ☐ Ms.

Marital status:
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed

Social Security #

Preferred Language:

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Caucasian or White
☐ Native Hawaiian or Other Pacific Islander
☐ Other
☐ Unknown

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Date of Birth:

Gender:
☐ Male ☐ Female

Street Address:

City:

State and Zip Code:

Home Phone #:

Work Phone #:

E-mail Address:

Cell Phone #:

Occupation:

Employer:

How did you hear about us? (Please check one box):

☐ Physician: _____

☐ Family/Friend

☐ Health Fair

☐ Newspaper / Radio

☐ TV

☐ Telephone directory

☐ Web Site: _____

☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to Patient:

Home Phone #: ( )

Work Phone #: ( )

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Primary Insurance Carrier:

Primary Policy Holder's Name:

Patient Relationship to Policy Holder:

Policy #:

Group #:

Policy Holder's Social Security #:

Policy Holder's Date of Birth:

Name of Secondary Insurance (if applicable):

Secondary Policy Holder's Name:

Secondary Group #:

Secondary Policy #:

Primary Care Physician and Pharmacy

Primary Physician:

Referring Physician:

Preferred Pharmacy and Address:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize LSU Healthcare Network or insurance company to release any information required to process my claims.

Authorization to Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.

Consent for Examination: I hereby consent to such examination procedures, as in the judgment of my physicians, may be considered necessary or advisable while a patient at the LSU Healthcare Network ("LSUHN"). I recognize that LSUHN manages teaching and research facilities, and that my treatment and care will be observed and in some instances aided by physicians and/or technicians under supervision.

Patient/Guardian signature:

Date:

1542 Tulane Ave., Suite 123HCN New Orleans, Louisiana 70112 (504) 412-1100

LSU Health Healthcare Network

Patient Name_____ Date of Birth_____

Allergies: Medications, Environmental, & Food:

Allergies:	Reaction:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications:

Please list all current medications and dosages:

Medications:	Dosages:	Medications:	Dosages:

Surgeries/Operations:

Please list dates of all surgeries and operations:

Please print a preferred pharmacy:

(Name and General Location)

_____

LSU Health Healthcare Network

Patient Name:_____ Date of Birth:_____

Medical History:

Diagnosis	**Your** Past Medical History		**Family's** Past Medical History		Family Member
Alcoholism	Yes	No	Yes	No	
Anemia	Yes	No	Yes	No	
Arthritis	Yes	No	Yes	No	
Asthma	Yes	No	Yes	No	
Blood Clot	Yes	No	Yes	No	
Breast Cancer	Yes	No	Yes	No	
Colon Cancer	Yes	No	Yes	No	
Prostate Cancer	Yes	No	Yes	No	
Other Cancers:	Yes	No	Yes	No	
COPD	Yes	No	Yes	No	
Depression	Yes	No	Yes	No	
Diabetes	Yes	No	Yes	No	
Drug Abuse	Yes	No	Yes	No	
Eczema, Hives, Rash	Yes	No	Yes	No	
Epilepsy	Yes	No	Yes	No	
Glaucoma	Yes	No	Yes	No	
Heart Attack	Yes	No	Yes	No	
Heart Disease	Yes	No	Yes	No	
High Blood Pressure	Yes	No	Yes	No	
High Cholesterol	Yes	No	Yes	No	
Stroke	Yes	No	Yes	No	
Thyroid Problems	Yes	No	Yes	No	
Other	Yes	No	Yes	No	

LSU Health Healthcare Network

Patient Name:_____ Date of Birth:_____

Social History:

Do you have any children? : Yes No How many? _____

Names and Dates of Birth:

_____ _____

_____ _____

_____ _____

Do you drink alcoholic beverages? Yes No

Beer Wine Liquor (Circle all that apply)

Do you use tobacco? Yes No

Cigarettes Cigars Chewing tobacco (Circle all that apply)

How often? _____ Have you ever stopped? Yes No When? _____

Do you use illicit drugs? Yes No

Marijuana Cocaine Prescription Drugs Other:_____

Immunization History: Please list dates

Tetanus Injection	
Flu Injection	
Pneumonia Injection	
Hepatitis B	
Gardisil (HPV Vaccine)	

Health Maintenance: Please list dates

Colonoscopy	
Last Mammogram	
Last Pap Smear	
PSA/Prostate Test	
Dexascan/Bone Scanning	

AUTHORIZATION

General Consent to Treatment:

I agree and consent to a physical examination by the patient's physician(s). I understand that additional diagnostic procedures and treatment may be recommended by the physician(s) and will be discussed with me before being done. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

Release of Information:

I authorize physicians providing service on behalf of the patient to release all billing and medical information (including information concerning substance abuse, psychological treatment, psychiatric treatment, and HIV status, (if applicable)) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid, (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party name on this patient information form (or any of their agents or representatives(, when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

Medicare Patients:

I request that payment of authorized Medicare benefits to be made to LSU Healthcare Network, on my behalf, for any services furnished by that provider.

Assignment of Third Party Coverage:

A. I authorize any third party payor to pay directly to the physicians providing services to the patient, all benefits due and payable as a result of services rendered.
B. I authorize assignment to the physician who has provided services to the patient the insured's rights to penalties and attorney's fees in the event that the insurer fails to timely pay such benefits in accordance with Louisiana Law (La R.S. 22:657).

Acknowledgement of Responsibility to Pay for Services:

I understand that the physician, as a courtesy, will file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law and in consideration of the services provided, I will pay any charges, which for any reason, are not paid by any third party payor unless there is a specific written agreement between the physician and the patient or between the physician and the payor. Failure to pay any charges when due, or, to make arrangements with the LSU Healthcare Network for a financial payment plan, may result in the denial of further services or dismissal from the LSU Healthcare Network as a patient. I also understand for any payments made by checks that, for all returned checks; I will pay an NSF Fee of $25.00 for that NSF check.

Date: _____ **Patient's Signature:** _____

PATIENT INFORMATION

You are advised that any medication, both prescribed and over-the-counter, can cause possible side effects, allergic reaction or other adverse reactions. These risks are usually minimal. If any reactions occur while taking medications, it is your responsibility to notify a physician immediately.

Certain medications, surgical procedures and x-ray examinations should not be taken/performed during pregnancy; therefore, it is your responsibility to inform your medical provider if you are or think you could be pregnant.

As always, smoking is hazardous to your health. In addition, the use of tobacco products with certain medications can possibly cause medical problems.

_____

Patient's Signature
Signature implies that you read and understand the above statement.

(Revised 10/2012)

LSU Health
Healthcare Network

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of the LSU Healthcare Network, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of the LSU Healthcare Network.

Name and relationship of person you wish to allow access - for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity **Relationship**

_____

_____

_____

_____

_____

_____

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the LSU Healthcare Network and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the LSU Healthcare Network's Privacy Officer at the Health Information Management Department. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Regardless of whether you provide us with this authorization, we will provide you with medical services or conduct payment operations. However, if your treatment is for any of the following purposes, we have the right not to provide you with medical services:

1. If your treatment is related to research
2. If health care services are provided to you solely for the purpose of creating protected health information for disclosure to a third party

_____
Patient's Signature or Personal Representative

_____
Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Send correspondence to:

LSU Healthcare Network
Attn: Health Information Management Department
1542 Tulane Ave., Room 235 L
New Orleans, LA 70112

I have been provided with and reviewed the "Patients Rights and Responsibilities Pamphlet" and understand my responsibilities as a patient of LSU Healthcare Network (LSUHN). I also understand that should I choose **not** to uphold my responsibilities, LSUHN has the right to delay or reschedule my appointment until my responsibilities are met.

I have also reviewed the LSUHN's Notice of Privacy Practices.

Date: _____

Patient Name: (Please Print) _____

Patient Date of Birth: _____/ _____/ _____

Patient/ Guardian Signature: _____

Relationship to Patient: _____

Comments: _____

_____

_____

_____

_____

To be completed by staff:

Employee Witness: _____

Sent to scanning date: _____

1542 Tulane Avenue
Suite 123-HCN
New Orleans, LA 70112

P 504.412.1100
F 504.412.1406