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 _____________________

Preferred contact number: (circle one) Home Work Mobile
Would you like to receive text message (SMS) appointment reminders? Yes ☐ No ☐

Home phone ______________________ Work phone ___________________ Mobile phone ____________________

Email address ________________________________ Language ☐ English ☐ Spanish ☐ Other _______________

Primary Care Physician (PCP) ___________________________ Referring MD (if different than PCP) ____________________________

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
No Answer

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

==

Responsible Party Information (If different from patient)

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

Date of Birth ________________ other known name(s) ____

Mailing Address ___________________________________ ____________________ _______________ ________
City State Zip

Parish _____________________ Relationship to patient _______________________

Home phone ______________________ Work phone __________________ Mobile phone ________________________

==

Employer (Responsible party if patient is a child) ____

Employer address _______________________________ _____________________ _________________ ___________
City State Zip

Employer phone ________________________

1/4/2016

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

Policy Holder Information (if different from patient and responsible party)

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

Date of Birth _______________ other known name(s) ____

Mailing Address __________________________________ ____________________ _______________ _______
City State Zip

Parish ____________________ Relationship to patient ____________________

Home phone _____________________ Work phone __________________ Mobile phone _______________________

Employer ____

Employer address _____________________________ ____________________ ________________ ___________
City State Zip

Employer phone _______________________

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 __________________

(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 __________________

==

By initialing next to each item below, then signing my name at the bottom of this form, I agree to the following:

______ I hereby acknowledge that I have read and fully understand the terms and provisions set forth in Our Lady of the Lake Physician Group, LLC's General Consent for Treatment form, including, but not limited to, the sections pertaining to consent to treatment, Medical Education, the use of Photography and Other Recordings, and the Authorization for Healthcare Related Calls, Texts and E-mails. In accordance with the General Consent for Treatment form, I do hereby consent to and authorize treatment by the physicians, physician

assistants, nurse practitioners, resident physicians, fellows, health care students, therapists, interns, nurses, and any other clinical staff of Our Lady of the Lake Physician Group, LLC and certain outpatient departments of Our Lady of the Lake Hospital, Inc.

______ I agree to pay for all financial obligations and abide by the terms and provisions of the Financial, Cancellation and Dismissal Policy and Patient Responsibilities form of Our Lady of the Lake Physician Group, LLC, which I acknowledge that I have read and fully understand, including the sections pertaining to Payment Guarantee and Insurance Authorization/Assignment of Insurance Benefits, Precertification, 24-Hour Cancellation policy, Termination of Physician-Patient Relationship policy, Other Physician Charges and Medical Records Copying Fees.

Print Name: ___________________________ Signature of Patient: _______________________ Time: __________ Date: __________