Patient Name: ______________________________
Patient DOB: ______________________________

Our Lady of the Lake Physician Group
Lourdes Physician Group
St. Francis Medical Group

PATIENT INFORMATION SHEET

MRN (Epic): ______________________

Name: ____ **SSN:** _____________________
Last *First* *Middle*

Sex: M F **Date of Birth:** ____________ **Other Known Name(s):** __________________________

Mailing Address: ____
Street *City* *State* *Zip*

Preferred Contact Number (circle one): Home Work Cell

Home Phone: _______________ **Work Phone:** _________________ **Cell Phone:** ________________

Email Address: ____

Preferred Language (circle one): English Spanish Other: ___________________

Please circle one option for each of the categories below.

Marital Status	Ethnicity	Race
Married	Hispanic or Latino	American Indian/Alaskan Native
Divorced	Non-Hispanic or Non-Latino	Asian
Legally Separated	Unknown	Black/African American
Single	Other	Native Hawaiian/Pacific Islander
Widowed		White/Caucasian
Significant Other/Partner		Unknown
		Other

Primary Care Physician (PCP): ____

Referring MD (if different than PCP): ____

Emergency Contact: ____

Phone: __________________________________ **Relationship to Patient:** _____________________

Patient Name: ________________________________
Patient DOB: ________________________________

REPONSIBLE PARTY INFORMATION

(if different from patient)

Primary Guardian: __________________________
Last First MI

Relationship to Patient: _____________________

Mailing Address: ____________________________

City/State/Zip: _____________________________

Parish/County: _____________________________

Home Phone: ________________________________

Cell Phone: _________________________________

Date of Birth: _______________________________

SSN: ______________________________________

Employment Status (circle one):

Active Military Duty
Disabled
Full-Time
Part-Time
Part-Time Student
Retired
Self-Employed
Unemployed
Unknown

Secondary Guardian: _________________________
Last First MI

Relationship to Patient: ______________________

Mailing Address: ____________________________

City/State/Zip: ______________________________

Parish/County: ______________________________

Home Phone: ________________________________

Cell Phone: _________________________________

Date of Birth: ________________________________

SSN: ______________________________________

Employment Status (circle one):

Active Military Duty
Disabled
Full-Time
Part-Time
Part-Time Student
Retired
Self-Employed
Unemployed
Unknown

INSURANCE POLICY HOLDER INFORMATION

(if different from patient and responsible party)

Name: ____ **SSN:** _______________________
Last First Middle

Sex: M F **Date of Birth:** _____________ **Other Known Name(s):** ____________________________

Relationship to Patient: ____

Mailing Address: ____
Street City State Zip

Parish/County: ____

Home Phone: _________________ **Work Phone:** ___________________ **Cell Phone:** __________________

Patient Name: ______________________________
Patient DOB: ______________________________

Employment Status (circle one):

Active Military Duty	Part-Time	Self-Employed
Disabled	Part-Time Student	Unemployed
Full-Time	Retired	Unknown

INSURANCE INFORMATION

Primary Coverage

Insurance Company: ________________________

Insurance Address: ________________________

City/State/Zip: ________________________

Phone: ________________________

Insurance ID Number: ________________________

Effective Date: ________________________

Group Number: ________________________

Covered Through (circle one):

Current Employer
Retirement
COBRA/Continuation of Benefits

Employer: ________________________

Employer Address: ________________________

City/State/Zip: ________________________

Employer Phone: ________________________

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

Secondary Coverage

Insurance Company: ________________________

Insurance Address: ________________________

City/State/Zip: ________________________

Phone: ________________________

Insurance ID Number: ________________________

Effective Date: ________________________

Group Number: ________________________

Covered Through (circle one):

Current Employer
Retirement
COBRA/Continuation of Benefits

Employer: ________________________

Employer Address: ________________________

City/State/Zip: ________________________

Employer Phone: ________________________

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

ADVANCED DIRECTIVES

Do you have an Advance Directive, such as a living will or durable power of attorney (circle one)?

Yes No

If yes, please provide a copy to the front desk. If no, would you like information about an Advance Directive (circle one)?

Yes No

Patient Name: ______________________________
Patient DOB: ______________________________

SIGNATURE

By signing below, I certify that all information is true and correct to the best of my knowledge.

Patient Name (print): ____

Patient Signature: ____

Date: __________________________________ **Time:** ___________________________________

Legal Guardian Name (print): ____

Legal Guardian Signature: ____

Date: __________________________________ **Time:** ___________________________________