

*****PATIENT INFORMATION PLEASE PRINT**

NAME (FIRST, MIDDLE INITIAL, LAST) _____ SEX _____
MAILING ADDRESS _____ APT/LOT # _____ CITY _____
STATE _____ ZIP _____ PHONE # _____ DR.LIC# _____
SOCIAL SECURITY # _____ PATIENT'S DATE OF BIRTH _____
PLACE OF EMPLOYMENT _____ WORK# _____
MARITAL STATUS _____ PRIMARY CARE PHYSICIAN _____
EMERGENCY CONTACT NAME _____ PHONE # _____
RELATIONSHIP _____

*****RESPONSIBLE PARTY INFORMATION PLEASE PRINT**

NAME _____ (PARENT IF MINOR)
MAILING ADDRESS _____ APT/LOT _____
CITY _____ STATE _____ ZIP CODE _____
PHONE # _____ DATE OF BIRTH _____ MARITAL STATUS _____
SOCIAL SECURITY # _____ DRIVER'S LIC# _____
PLACE OF EMPLOYMENT _____ EMPL PHONE# _____
EMPLOYER'S ADDRESS _____

*****INSURANCE INFORMATION PLEASE PRINT**

NAME OF PERSON CARRYING INSURANCE FOR PATIENT _____
ADDRESS (IF DIFFERENT FROM ABOVE) _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ PHONE# _____
PLACE OF EMPLOYMENT _____ EMPL PHONE# _____
NAME OF INSURANCE PLAN _____
ADDRESS OF INSURANCE PLAN _____
MEMBER # _____ GROUP # _____
IS THIS VISIT THE RESULT OF AN ACCIDENT _____ YES _____ NO DID THIS ACCIDENT OCCUR AT WORK _____

REASON FOR TODAY'S VISIT

I CONSENT TO TREATMENT FOR MYSELF OR ABOVE MINOR CHILD. I UNDERSTAND THAT THE EXAMINATION AND/OR MEDICAL TREATMENT I WILL RECEIVE IS **NOT** INTENDED TO REPLACE COMPLETE MEDICAL CARE BY MY PERSONAL PRIMARY CARE PHYSICIAN. I AM AWARE THAT I WILL BE RESPONSIBLE FOR CO-PAYMENT OR FULL PAYMENT AT THE TIME OF SERVICE. ANY PRE-CERTIFICATION REQUIREMENT THAT MY INSURANCE COMPANY REQUIRES IS MY RESPONSIBILITY TO MAKE. FURTHERMORE, I ALLOW PLAQUEMINES MEDICAL CENTER TO RELEASE TO MY INSURANCE COMPANY TREATMENT AND BILLING INFORMATION, AS REQUESTED TO PROCESS MY CLAIM. I ALLOW PLAQUEMINES MEDICAL CENTER TO ACCEPT ASSIGNED PAYMENTS MADE BY MY INSURANCE COMPANY ON MY BE HALF. I UNDERSTAND THAT BY MY LACK OF PAYMENT OR IF MY INSURANCE COMPANY DENIES PAYMENT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR SERVICES RENDERED. MY FAILURE TO PAY MAY RESULT IN COLLECTION PROCEEDINGS. IN ADDITION, I AUTHORIZE PLAQUEMINES MEDICAL CENTER TO RELEASE TO MY PRIMARY CARE PHYSICIAN OR SPECIALTY REFERRAL, ANY AND ALL INFORMATION RELATED TO MY TREATMENT AT THIS CLINIC. IN THE EVENT OF NON PAYMENT OF PATIENT RESPONSIBILITY, LATE FEES MAY APPLY.

PATIENT SIGNATURE OR PARENT IF MINOR

DATE