27136 HIGHWAY 23, PORT SULPHUR, LA
70083 PH: 504-564-3344 FAX: 504-564-0174
PLAQUEMINESMEDICALCENTER.COM

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Preferred Pharmacy:	Email Address:	Birth Date:	Age:	Race:	Sex: ☐ M ☐ F

Mailing Address:	Social Security No.:	Home/Cell Number: ( )

City:	State:	ZIP Code:	

Occupation:	Employer:	Employer Phone No.: ( )

Is this visit the result of an accident? Yes or No Did this accident occur at work? Yes or No Are you a new patient? Yes or No

REASON FOR TODAY'S VISIT:

INSURANCE INFORMATION

Person responsible for bill:	Birth Date: / /	Age:	Race:	Home Phone No.: ( )

Address (If different):

Occupation:	Employer:	Employer Address:	Employer Phone No.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance: ❑ Blue Cross/Blue Shield ❑ Medicaid ❑ United HealthCare ❑ LA HealthCare Connections ❑ Amerigroup ❑ Humana ❑*Medicare* ❑ Other ❑ Aetna

Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance:	Subscriber's Name:	Group No.:	Policy No.:

IN CASE OF EMERGENCY

Name of friend or relative	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I CONSENT TO TREATMENT FOR MYSELF OR ABOVE MINOR CHILD. I AM AWARE THAT I WILL BE RESPONSIBLE FOR CO-PAYMENT OR FULL PAYMENT AT THE TIME OF SERVICE. ANY PRE-CERTICATION REQUIREMENT THAT MY INSURANCE COMPANY REQUIRES IS MY RESPONSIBILITY TO MAKE. FURTHERMORE, I ALLOW PLAQUEMINES MEDICAL CENTER TO RELEASE 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 BEHALF. 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 ANY INFORMATION PERTAINING TO MY TREAMENT TO A SPECIALITY REFERRAL FOR FURTHER TREATMENT. IN THE EVENT OF NON PAYMENT OF PATIENT RESPONSIBILITY, LATE FEES MAY APPLY.

Patient/Guardian signature	*Date*

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: ___________________________ Date: ____________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "X" to indicate your answer)

	Not At All 0	Several Days 1	More Than Half the Days 2	Nearly Every Day 3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking slowly that other people could have noticed; of the opposite, being so fidgety or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Total Score: ☐

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW HEALTH INFORMATION ABOUT MYSELF AS A PATIENT OF PLAQUEMINES MEDICAL CENTER, MAY BE USED OR DISCLOSED AND HOW I CAN GET ACCESS TO THIS INFORMATION.

____
PATIENT OR GUARANTOR SIGNATURE

____
IF GUARANTOR, SPECIFY RELATIONSHIP

____
PRINTED NAME OF PATIENT OR GUARANTOR

____
DATE