Family Doctor Clinic

429 West Airline Highway • Suite B • LaPlace, LA 70068
(985) 652-3344

Account # ____________________ F/C ____________________

Resp. Party # ____________________ DR ____________________ LOC ______

I. PATIENT INFORMATION

Patient ____________________ (Last / First / Middle) Title: Mr./Mrs./Other ________ Suffix: Jr./Sr./Other ________

Mailing Address ____________________ ____________________ (City / State / Zip)

Hm. Ph. __________ Wk. Ph. __________ Ext. ______

Cell# ____________________ Date of Birth ____________________ Sex: ❑ M ❑ F

Social Security # ____________________ Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Employer ____________________

Emergency Contact: Name: ____________________ Phone: ____________________

II. RESPONSIBLE PARTY INFORMATION

SEND STATEMENT TO

Responsible Party ____________________ (Last / First / Middle) Title: Mr./Mrs./Other ________ Suffix: Jr./Sr./Other ________

Mailing Address ____________________ ____________________ (City / State / Zip)

Hm. Ph. __________ Wk. Ph. __________ Ext. ______ Date of Birth ____________________ Sex: ❑ M ❑ F

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Social Security # ____________________ Student: ❑ Full ❑ Part-time

Employer ____________________ Employment Status: ❑ Full-time ❑ Self-Employed ❑ Part-time ❑ Not Employed ❑ Unknown ❑ Retired ❑ Military Active

III. INSURANCE INFORMATION

Insurance Company ____________________
Address ____________________
____________________ (City / State / Zip)
Patient's Relationship to Insured: ❑ Self ❑ Child ❑ Mate ❑ Other
Group # __________ Policy # __________
CoPay: Primary Care __________ Specialist __________
Insured's Name ____________________

Insurance Company ____________________
Address ____________________
____________________ (City / State / Zip)
Patient's Relationship to Insured: ❑ Self ❑ Child ❑ Mate ❑ Other
Group # __________ Policy # __________
CoPay: Primary Care __________ Specialist __________
Insured's Name ____________________

IV. INSURED INFORMATION

INSURANCE POLICY HOLDER

Address ____________________
____________________ (City / State / Zip)
Hm. Ph. __________ Wk. Ph. __________ Ext. ______
Date of Birth ____________________ Sex: ❑ M ❑ F
Employer __________ Status __________

Address ____________________
____________________ (City / State / Zip)
Hm. Ph. __________ Wk. Ph. __________ Ext. ______
Date of Birth ____________________ Sex: ❑ M ❑ F
Employer __________ Status __________

I hereby authorize the above listed insurance companies to pay directly to Family Doctor Clinic benefits due me, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be paid. I authorize Family Doctor Clinic to release information to the insurance company for my claims to be paid. Please attach copy of insurance card.

____________________ Signature ____________________ Date

1013323 10/10

THE FAMILY DOCTOR CLINIC OF LAPLACE

429 WEST AIRLINE HIGHWAY, SUITE B
LAPLACE, LOUISIANA 70068
TELEPHONE 652-3344

PATIENT HISTORY LIST

NAME: ______________________________

DATE OF BIRTH: ______ / ______ / ______ SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

PLACE OF EMPLOYMENT: ______________________________

RETIRED? ☐ YES ☐ NO

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO

If so, please list ______________________________

____

ARE YOU CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO

If so, please list ______________________________

____

DO YOU HAVE/HAD ANY OF THE FOLLOWING?

Diabetes: ☐ Yes ☐ No HBP: ☐ Yes ☐ No Heart Disease: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No

Other: ______________________________

DOES ANY FAMILY MEMBER HAVE/ HAD ANY OF THE FOLLOWING?

Diabetes: ☐ Yes ☐ No HBP: ☐ Yes ☐ No Heart Disease: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No

Other: ______________________________

DO YOU SMOKE? ☐ NO ☐ YES ______ # Packs Per Day

DO YOU DRINK ALCOHOL? ☐ NO ☐ YES ☐ Socially

LIST MAJOR SURGERIES: ______________________________

____

____

REASON FOR VISIT TODAY: ______________________________

____

______________________________ SIGNATURE

______________________________ DATE

RECEIPT OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I acknowledge that I have recieved the Physician's Notice of Privacy Practices.

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________ ______________
Patient's authorized representative signature Relationship to patient Date

______________________________ ______________________________
Witness Signature Witness Job Title

Patient is unable to sign this receipt because ______________________________

____

Patient indicated exceptions to the use or disclosure of his/her protected health information.

These exceptions are as follows:

____

PATIENT INFORMATION SHEET

NAME:____________________________ DOB:____________ DATE:__________

ALLERGIES:____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:________________

Alcohol: Currently Past Never Drinks/day:________________

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	**OTC and vitamins**

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD	COPD	High Cholesterol	Peptic Ulcer
Alcoholism	Dementia	HIV	Psoriasis
Allergies, Seasonal	Depression	Hepatitis	Pulmonary Embolism (PE)
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Rheumatoid Arthritis
Anxiety	Diverticulitis	Kidney Stones	Sciatica
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Kidney Disease	Seizure Disorder
Arthritis	Eczema	Lupus	Sleep Apnea
Asthma	Emphysema	Liver Disease	Stroke
Bipolar	Gallstones	Macular Degeneration	Thyroid Disorder
Bladder problems/Incontinence	GERD (Acid Reflux)	Migraines	Ulcerative Colitis
Bleeding problems	Glaucoma	Nosebleeds	
Cancer:______________	Heart Disease	Neuropathy	
Carpal Tunnel	Heart Attack (MI)	Osteopenia/Osteoporosis	
Headaches	Hiatal Hernia	Parkinson's Disease	
Crohn's Disease	High Blood Pressure	Peripheral Vascular Disease	

Last Menstrual Period	Yes/No Date:____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dxa (Bone Density)	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

____

____

Surgical History: Please list all prior surgeries and approximate dates performed.

______________________ ______________________

______________________ ______________________

______________________ ______________________

FAMILY HISTORY:

FATHER: Living: Age________ Deceased: Age________

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:____

MOTHER: Living: Age_________ Deceased: Age:__________

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:____

Siblings:____

____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

____

____

Patient signature:____________________________ Date:____________________

Provider reviewed:____________________________ Date:____________________