LAFAYETTE ARTHRITIS AND ENDOCRINE CLINIC

4212 West Congress Street, Suite 2300A

Lafayette, LA 70506

PHONE (337) 237-7801

FAX (337) 233-5799

**JUSTIN FONTENOT, M.D.**

ENDOCRINOLOGY –**Suite 2300B when you arrive for your appointment**

Dear Patient:

Welcome to Lafayette Arthritis and Endocrine Clinic. We are pleased that you have chosen us as your health care specialist, and look forward to seeing you at

\_\_\_\_\_\_\_\_\_\_\_\_\_ ON \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Time Day Date

The enclosed forms are necessary to open your medical record. These include the **Patient Registration Form, Authorization to Release Information, Information for Your Physician and Notice of Privacy Practices** forms. Please complete all forms, **PRIOR** to your visit, sign and date where indicated. By doing so, your wait time, and the wait of those who are appointed after you, should be lessened.

**Also, bring all of your current medications and insurance card(s) with you to our office for EVERY appointment, as well as all current imaging and lab work deemed pertinent by the referring physician.** Bringing these items will help keep the cost of your visit down and may prevent having to repeat labs and imaging.

Our office requires a 24-hour cancellation notice. If you cannot make your scheduled appointment or need to reschedule, contact our office 24-hours prior. If we do not receive notice: **YOU** (not your insurance) will be billed for a missed appointment. Missed new patient appointments will be charged $50.00 and revisits $25.00. If an emergency occurs, please contact our office.

If you have any questions or need assistance with any of the questions on the forms, we will be glad to help you when you come or call us at 337-237-7801.

Again, welcome to our practice. We look forward to meeting you at your first appointment.

Sincerely,

Lafayette Arthritis and Endocrine Clinic

**DIRECTIONS**

**THIS IS FOR YOU TO KEEP—DO NOT MAIL BACK TO US**

LAFAYETTE ARTHRITIS AND ENDOCRINE CLINIC has moved!

Our new address is now 4212 West Congress Street, Suite 2300A Lafayette, LA 70506. **(mailing)**

Suite 2300B (Endocrine Office) **when you arrive for your appt.**



Information for your physician: **Dr. Justin Fontenot** Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions. It will help your physician to know about your health and family medical history.

Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_ Zip\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male\_\_\_ Female\_\_\_ Race \_\_\_\_\_Ethnicity\_\_\_\_\_\_ Name of responsible party (if other than patient): \_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

 Living Age or age of death Present Health or cause of death

Father…. Yes \_\_\_\_ No \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother… Yes \_\_\_\_ No \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse…. Yes \_\_\_\_ No\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers # Living \_\_\_\_\_\_\_\_\_ Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 # Dead \_\_\_\_\_\_\_\_\_ Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sisters # Living \_\_\_\_\_\_\_\_\_ Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 # Dead \_\_\_\_\_\_\_\_\_\_ Cause of Death \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children Living \_\_\_\_\_\_\_\_\_\_\_ Ages and Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children Dead \_\_\_\_\_\_\_\_\_\_\_ Ages and Causes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle illnesses which occurred in any of your Blood Relatives.

Diabetes Cancer Bleeding Tendency Kidney Disease Tuberculosis

Heart Disease Stroke High Blood Pressure Nervous Illness Arthritis

Please circle illnesses or condition you have had.

Diabetes Glaucoma Heart Trouble Hypertension Vein Trouble

Cancer Asthma Jaundice Arthritis Bleeding Tendency

Ulcers Pneumonia Kidney Disease Rheumatic Fever Nervous Disorder

Previous Operations: Please list, giving year, and hospital where performed. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had serious injuries, broken bone, etc.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had allergy or sensitivity to medicine or other substances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Tobacco now? \_\_\_\_\_\_\_\_ In the past? \_\_\_\_\_\_\_\_ Daily amount? \_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use per week if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken cortisone type drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oral Contraceptives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your main medical problem at the present time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List current medications, dose and frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not referred, would you like a report sent to your family physician \_\_\_\_\_Yes \_\_\_\_\_ No

Name of family physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT CONFIDENTIALITY QUESTIONNAIRE

***Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**1. Can confidential messages be left on your telephone answering machine?**

**YES\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_**

**2. Please print the telephone number(s) where you want to receive calls about your appointments, lab results, x-ray results and other health care information if other than your home phone number. (This could be a work number or cellular number.)**

*\*I am fully aware that a cell phone is not a secure and private line*.

**(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. If the patient is under the age of 18, please list all family members who will be allowed to request medical services for and/or accompany the patient when receiving medical services. (If someone other than the individual(s) listed below accompanies the patient in the future, a note from a parent or guardian must accompany that individual.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I am fully aware that my health care information can be transmitted by electronic transmission, by fax transmittal, by internet or by e-mail.**

**I understand that this information is effective with the date of signing and that changes in this information will require completion of a new form and are my responsibility.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Guardian if under age 18 years)**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information can and will be used to:

**a.** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who

 may be involved in that treatment directly and indirectly.

**b**. Obtain payment from third-party payers.

**c.** Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Printed Name Employee Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Authorization to Release Information

I hereby authorize Lafayette Arthritis and Endocrine Clinic, or any holder of medical information about me to release to the Health Care Financing Administration and Its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable for related services.

Assignment of Benefits

I request that authorized Medicare or Insurance payments of medical benefits be made to Lafayette Arthritis and Endocrine Clinic (to be used only if necessary to file claims).

Guarantor Responsibility

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Lafayette Arthritis and Endocrine Clinic, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.

This authorization and assignment may be revoked by me at any time by a written notice. I agree that a photocopy of this form may be used in lieu of the original.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices, describing the privacy practices and safeguard as well as my right with respect to my protected health information maintained and used by Lafayette Arthritis and Endocrine Clinic.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Insured/Patient Date

\*PLEASE PRINT\* Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST FIRST MIDDLE

MALE\_\_\_\_ FEMALE\_\_\_\_ \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

 SEX DATE OF BIRTH S.S NUMBER

**GUARANTOR INFORMATION**

GUARANTOR NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 HOME PHONE: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK/CELL: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE TYPE: Medicare Medicaid Medigap Workers Comp Group Individual

 Commercial Litigation Supplement Long Term Auto Other: \_\_\_\_\_\_\_\_\_\_\_

IC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER

 (CIRCLE ONE):

1 Male Patient is subscriber

2 Female Patient is subscriber

3 Male Spouse of subscriber

4 Female Spouse of subscriber

5 Male Child of subscriber

6 Female Child of subscriber

7 Other:

CARRIER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER INFORMATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST NAME FIRST NAME MIDDLE INITIAL

MALE\_\_\_\_ FEMALE\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SEX DATE OF BIRTH S.S.NUMBER

MAIL CLAIM TO: (CIRCLE ONE) INSURANCE CO. EMPLOYER PATIENT

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS. POLICY#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. GROUP# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE TYPE: Medicare Medicaid Medigap Workers Comp Group Individual

 Commercial Litigation Supplement Long Term Auto Other: \_\_\_\_\_\_\_\_\_\_\_

IC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CARRIER PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT RELATIONSHIP TO SUBSCRIBER

 (CIRCLE ONE):

1 Male Patient is subscriber

2 Female Patient is subscriber

3 Male Spouse of subscriber

4 Female Spouse of subscriber

5 Male Child of subscriber

6 Female Child of subscriber

7 Other:

CARRIER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER INFORMATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST NAME FIRST NAME MIDDLE INITIAL

MALE\_\_\_\_ FEMALE\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SEX DATE OF BIRTH S.S.NUMBER

MAIL CLAIM TO: (CIRCLE ONE) INSURANCE CO. EMPLOYER PATIENT

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INS. POLICY#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INS. GROUP# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY INFO: A friend or relative (Not responsible party)**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY-DO NOT WRITE BELOW THIS LINE**

REFERRING DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REF DR #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAEC DOCTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DR #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you are a diabetic, please bring your glucose meter and logbook.
2. Please bring list of your medications, or your medicines in their bottles. Including your insulin. It can be kept at room temperature.
3. Please bring your welcome packet filled out. If not completed, your visit may be delayed.
4. If you did not receive a welcome packet let the receptionist know when you check in and it will be provided.
5. Please arrive 15 minutes early for your appointment.
6. If you are more than 15 minutes late EXPECT TO BE RESCHEDULED unless circumstances are truly extenuating.
7. If you have a fasting blood work scheduled, do not skip your medications, unless specifically instructed to do so by a physician or physician’s office.