LOUISIANA WOMEN'S Healthcare

Please Print **PATIENT INFORMATION FORM** *Please Print*

In order to control our cost of billings, we request that your portion of our charges for office visits be paid at the conclusion of each visit.

Doctor	Account No.	Date

PATIENT

❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed

First Name	Middle/Maiden	Last Name	Date of Birth / Age

Address	Phone - Home

City, State and Zip Code	Phone - Cell

Name of Employer or School	Phone - Work

Employer's Address	Occupation

Social Security Number	Referred by	Religious Preference

List names of family members who are also patients of your doctor:	E-mail address

Spouse's name	Occupation	Date of Birth

Check what applies to you

RACE: ❑ White ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Not Hawaiian/Pacific Islander ❑ Other Race_____ ❑ Unknown ❑ Declined PRIMARY LANGUAGE:_____

ETHNICITY: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown ❑ Declined

PREFERRED COMMUNICATIONS: ❑ Email ❑ Fax ❑ Mail ❑ Text ❑ Patient Portal ❑ Other ❑ Unknown ❑ Declined

Preferred Pharmacy and Location

RESPONSIBLE PARTY

❑ Self
❑ Spouse
❑ Parent
❑ Guardian
❑ Other

First Name	Middle/Maiden	Last Name	Social Security Number

Address	

City, State and Zip Code	Home Phone

Name of Employer	Work Phone

Employer's Address	

Referred by: ❑ Family Member ❑ Friend ❑ Another Physician ❑ Web Site ❑ Yellow Pages ❑ Advertisement

IN CASE OF EMERGENCY NOTIFY

Name	Address	Relation	Phone

INSURANCE INFORMATION

Type of Plan (Check One) ❑ HMO ❑ PPO ❑ POS ❑ INDEMNITY ❑ OTHER	Co-Pay Amount: _____	Type of Plan (Check One) ❑ HMO ❑ PPO ❑ POS ❑ INDEMNITY ❑ OTHER	Co-Pay Amount: _____
Primary Insurance		Secondary Insurance	
Insurance Address		Insurance Address	
Policy/Contract No.	Group No.	Policy/Contract No.	Group No.
Name of Policy Holder	Employer	Name of Policy Holder	Employer
Policy Holder's Soc. Sec. No.	Policy Holder's Date of Birth	Policy Holder's Soc. Sec. No.	Policy Holder's Date of Birth

RELEASE OF INFORMATION & FINANCIAL AGREEMENT

PLEASE BRING YOUR INSURANCE CARD TO EACH VISIT

I consent to treatment necessary for the above named patient. I authorize the release, via fax if necessary, of all medical records, including any and all records containing HIV and substance abuse, to my insurance company, if applicable. This authorization will remain in effect until revoked by me in writing.

Signed _____ Date _____

I agree to pay for all charges for treatment and understand that payment is due at the time of service. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to the physician. I further authorize and request insurance payments be made directly to LWH. I understand I am responsible for all charges not paid by my insurance company. If we are forced to turn your balance over to a collection agency, you will be responsible for the collection and attorney's fees, including court costs. All NSF checks will be subjected to a $25.00 return check fee. This assignment will remain in effect until revoked by me in writing.

Signed _____ Date _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have been given the opportunity to review and receive a copy of LWH's Notice of Privacy Practices.
I would like to receive a copy of amended notices. ❑ Yes ❑ No

Signed _____ Date _____

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