



## PATIENT REGISTRATION FORM

Patient Legal Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ May we text you? ☐ Yes ☐ No

Street or Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

E-Mail Address (Required for portal access) \_\_\_\_\_

May we email you educational information? ☐ Yes ☐ No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language (if other than English): \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy City: \_\_\_\_\_

Referred by: ☐ Dr. \_\_\_\_\_ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐ Yellow Pages ☐ Other: \_\_\_\_\_

Family Doctor Name: \_\_\_\_\_ Family Doctor Phone #: \_\_\_\_\_ Last Visit: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

Are you responsible for the bill? ☐ Yes ☐ No ☐ Check here if person responsible for bill is same as patient

If not: Name of Responsible Person: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Policyholder Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient | Guardian Signature: \_\_\_\_\_ Date | Time: \_\_\_\_\_



## CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

1. **CONSENT TO SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician (s).
2. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the physician/clinic in accordance with the charges listed on the claim and, if applicable, the physician/clinic's charity care and discounted payment policies and state and federal law. The physician/clinic may provide, upon my request, a reasonable estimated of charges for items and services based on the charge fee schedule. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the physician/clinic may bill my insurance company or health benefit plan but is not required to do so. I agree and understand, except where prohibited by law, the financial responsibility for the services rendered belong to me, the undersigned. I further understand that the obligation to pay the physician/clinic may not be deferred for any reason, including pending legal actions against other parties to recover medical cost. The physician/clinic shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including radiologist, pathologist, emergency physician, anesthesiology, hospitalist, and others if applicable will bill separately for their services. For your convenience we accept cash, personal checks, MasterCard, Visa, Discover, and American Express.
3. **REFERRALS:** If your insurance plan requires a referral from a Primary Care Physician, it is your responsibility to make sure that the form is received PRIOR to scheduling an appointment. If you do not have your referral, the practitioner will be happy to see you, but you will be financially responsible for your charges.
4. **PHYSICIAN/CLINIC TO ACT AS AGENT:** I irrevocable assign and transfer to the physician/clinic all rights, benefits, and any other interest in connection with any insurance plan health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the physician/clinic of all insurance and health plan benefits payable for any services rendered. I agree that the insurers or plans payment to the physician/clinic shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this physician/clinic to perfect, confirm, or validate this assignment. I also hereby authorize the physician/clinic, or its designee, to act on my half in any dispute with a managed care organization government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
5. **CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the clinic/physician to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.
6. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contact, unless I notify to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at the email address from the clinic/physician.
7. **ELECTION TO ELETRONICALLY TRANSMIT MEDICAL INFORMAITON AT DISCHARGE:** I authorize physician or clinic to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care providers(s) or facility (ies)

identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

8. **ELECIION TO PARTICIPATE IN HEALTH INFORMAITON EXCHANGE(S):** I hereby authorize physician/clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which physician/clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and, in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which physician/clinic participates may be found in the Notice of Privacy Practices, which is available upon request, and this list may be updated from time to time if and when physician/clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.
9. **PATIENT APPOINTMENT AND CONDUCT:** I understand that unless cancelled 24 hours in advance, you are expected to appear on time for your appointment. Three (3) or more missed appointments in a 12 month period will result in a warning letter and five (5) or more missed appointments in a 12 month period may result in dismissal from the practice upon provider review and patients will be asked to seek treatment elsewhere. I am expected to be respectful to clinic staff and other patients. This includes use of appropriate language and heavier. Patients who use profane language or cause physical harm or threaten to cause harm will be dismissed from the practice.
10. **HIPAA ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS:** I understand and have been provided with a Notice of Privacy Practices and patient rights that provides a more complete description of my health care information uses and disclosures.
11. **AUTHORIZATION TO DOWNLOAD PHARMACY INFORMATION:** I understand and authorize physician/clinic to download my last 13 months of prescription history.
12. **CONSENT TO PHOTOGRAPH:** I consent to photographs, videos or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.
13. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. U understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.
- ☐ Yes, I have executed an Advance Directive
- ☐ No, I have not executed an Advance Directive.

My signature indicates that I have read and fully understand this Patient Consent and Financial Agreement and have been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

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Signature of Patient or Legal Representative

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Date/Time

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Signature of Witness

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Date/Time



## PEDIATRIC MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_

Today's Health Concerns: \_\_\_\_\_

**MEDICATIONS:** Please list all prescription and non-prescription medications, Vitamins, home remedies, birth control, herbs etc.

| Medication Name | Dose | Frequency |
|-----------------|------|-----------|
|                 |      |           |
|                 |      |           |
|                 |      |           |

**ALLERGIES:** List all reactions to medicines, foods and other agents.

| Allergy | Reaction or Side Affect |
|---------|-------------------------|
|         |                         |
|         |                         |
|         |                         |

**\*\* If you are on 3 or more medications – please bring them with you to each appointment. \*\***

**PERSONAL MEDICAL HISTORY:** Please indicate whether the patient has had any of the following medical problems.

- ☐ Autism ☐ ADHD ☐ Allergies ☐ Anemia ☐ Asthma ☐ Bleeding Disorder ☐ Bronchiolitis  
☐ Chicken Pox ☐ Diabetes ☐ Eczema ☐ Fracture ☐ Handicap/disabilities ☐ Hearing problems  
☐ Heart murmur ☐ High Blood Pressure ☐ Kidney Disease ☐ Liver Disease ☐ Urinary Tract Infections  
☐ Vision Problem

Additional comments: \_\_\_\_\_

### HOSPITALIZATIONS:

Has your child stayed overnight in the hospital? ☐ Yes ☐ No

If yes, when and why? \_\_\_\_\_

Any Recent ER or Urgent Care visits? ☐ Yes ☐ No

**SURGERIES:** Please list all prior surgeries and approximate dates.

| Surgery | Date |
|---------|------|
|         |      |
|         |      |
|         |      |



## PEDIATRIC MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_

### IMMUNIZATIONS:

As far as you know are patient's vaccines up to date? ☐ Yes ☐ No

Were all vaccines administered in Louisiana? ☐ Yes ☐ No If not, where? \_\_\_\_\_

Previous Primary Care Physician: \_\_\_\_\_ Location (city|state): \_\_\_\_\_

### PREGNANCY & BIRTH:

Where was the patient born? \_\_\_\_\_

How many weeks pregnant at delivery? \_\_\_\_\_

Mode of Delivery ☐ Vaginal ☐ Caesarean

Birth Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz Birth Length \_\_\_\_\_ in

Were there any medical problems during pregnancy or abnormalities on ultrasounds? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Were there any problems during labor and delivery? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Did baby require NICU stay or any additional treatments? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

Did baby pass heart screening? ☐ Yes ☐ No

For Male Patients Only: Is your child circumcised? ☐ Yes ☐ No

### SAFETY:

What kind of car seat does patient use? ☐ Infant Seat ☐ Booster Seat ☐ Seatbelt only ☐ Convertible Seat

Do you have smoke detectors in the home? ☐ Yes ☐ No Carbon Monoxide Detectors? ☐ Yes ☐ No

Is violence in the home a concern? ☐ Yes ☐ No

Are there guns in the home? ☐ Yes ☐ No If yes, are they in a locked safe? ☐ Yes ☐ No

### DENTAL:

Has the patient seen a dentist? ☐ Yes ☐ No If yes, date of last visit \_\_\_\_\_. Is he/she up to date on checkups? ☐ Yes ☐ No

### DEVELOPMENT:

Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themselves, or feeding themselves? ☐ Yes ☐ No If yes, please explain: \_\_\_\_\_

Are there any area of concerns about language or speech development? ☐ Yes ☐ No If yes, please explain \_\_\_\_\_

For Female Patients Only: Age at first menstrual period \_\_\_\_\_

### SOCIAL HISTORY:

Are the patient's parents: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced

Mother's Occupation: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Any other caregivers involved in child's life? ☐ Yes ☐ No

Does the patient split time between two houses? Any other unique custody details?

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



## PEDIATRIC MEDICAL HISTORY FORM

Patient Name: \_\_\_\_\_

### Who lives at home with the patient? (Other adults or children)

| Name | Age | Relationship | Highest Level of Education |
|------|-----|--------------|----------------------------|
|      |     |              |                            |
|      |     |              |                            |

### SCHOOL/DAYCARE HISTORY:

Which school/ daycare does child attend? \_\_\_\_\_

Does the patient attend school/preschool? ☐ Yes ☐ No Current grade in school? \_\_\_\_\_

Do you have concerns with how the patient is doing in school? ☐ Yes ☐ No Or relationships with teachers or other students? ☐ Yes ☐ No

Does your child play any sports? ☐ Yes ☐ No What sport does your child play? \_\_\_\_\_

### FAMILY MEDICAL HISTORY: Please indicate whether anyone in the family has had any of the following medical problems.

☐ Asthma ☐ Eczema ☐ Blood Disorder ☐ Hip Dysplasia ☐ Migraines ☐ Seizures

☐ Strabismus (lazy eye) ☐ Mental Illness ☐ Sudden Death <55 years old

Other important family history: \_\_\_\_\_

## MINDEN PHYSICIAN PRACTICES PATIENT'S RIGHTS AND RESPONSIBILITIES

Minden Physician Practices Patient's Bill of Rights and Responsibilities, distributed to all patients upon request at any time during patient care.

Patients of Minden Physician Practice shall have the right to:

- Be treated equally and receive care without regard to age, sex, religion, race or creed;
- Receive care that is not determined by patient's ability to pay for service;
- Confidentiality of his/her clinical records;
- Be informed of all costs and expected payment from other resources;
- Be treated with respect for the individual patient's comfort, dignity and privacy;
- Be informed of his/her rights in advance of care being provided;
- Access information contained in his/her clinical records within a reasonable time frame;
- Make decisions regarding his/her care;
- Formulate advance directives and have staff/practitioners to comply with those directives;
- Maintain personal privacy and receive care in a safe setting;
- Be free from verbal and physical abuse or harassment from staff.

The Practice understands that:

- Providing, to the extent possible, information needed by professional staff in caring for the patient;
- Following instructions and guidelines given by those providing health care services.

### Communication Authorization

We take your medical confidentiality very seriously. We will not and cannot release information without your authorization. This authorization allows our staff members to speak only with individual(s) you designate in the event you are not available to receive phone calls or you have an adult individual that helps coordinate your medical care. As part of our Patient Privacy Policy, we will not leave any health information with any other persons unless you specifically authorize below.

\_\_\_\_\_ I do not authorize anyone to receive information regarding my medical care.

\_\_\_\_\_ I authorize my physician and staff of the clinic to speak with:

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ ☐ Appointments ☐ Account ☐ Lab/Test Results ☐ Medical Care

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ ☐ Appointments ☐ Account ☐ Lab/Test Results ☐ Medical Care

This authorization will remain in effect for one (1) year unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to this staff. I agree that should I desire to revoke this authorization, I will give written notices.

Printed Name of Patient or Representative: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_