2933 Cypress Street Ste 1
West Monroe, LA 71291

PATIENT INFORMATION ☐Adult ☐Child

Patient Name______________________ DOB ______________ Gender ☐M ☐F

Home Address______________________ City/State/Zip______________

Cell Number______________ Home Number______________ Drivers License Number______________

Social Security Number______________ Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Race__________ ☐ I choose not to answer Religion__________ ☐ I choose not to answer **Primary Language Spoken** __________

Employer______________________ Work Number______________

Spouse's Name | Parent's Name –if patient is a minor ______________________

Spouse | Parent's Social Security Number______________________ DOB______________

Spouse | Parent's Employer______________________ Work Number______________

In Case of Emergency – Contact______________________ Phone Number______________

Relationship to Patient______________________

INSURANCE INFORMATION **☐I do not have insurance – please skip this section**

Primary Insurance______________________ ID Number______________ Group Number______________

Secondary Insurance______________________ ID Number______________ Group Number______________

Medicare Number______________ Medicaid Number______________ Bayou Health Plan______________

Agreement:
All professional services rendered are the financial responsibility of the patient and/or legal guardian. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims.

Consent to release information:

Please note, by signing below, I hereby consent to my insurance carrier releasing all necessary information to Family Convenience Clinic regarding the status of my claim(s).

Assignment of benefits:

Further, I hereby authorize Family Convenience Clinic to furnish information to my insurance carrier concerning my medical history, illness and treatments. Further I authorize my insurance carrier to pay directly to Family Convenience Clinic all benefits to which I and/or my dependents may be eligible for the provision of healthcare services.

My signature indicates that I have read, understand, and agree to all the provisions above.

Signature______________________________ Date______________

ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Family Convenience Clinic's current Notice of Privacy Practices

______________________________ ______________________ ______________
Signature of Patient/Legal Guardian **Relationship to Patient** **Date**

AUTHORIZATION TO CONSENT

Release of Protected Health Information (PHI) If you wish to allow us to release your medical information to anyone other than yourself, please complete below: I consent to the release of PHI via telephone to the following person(s) until revoked by me in writing:

Name:______________________ Relationship:______________ Phone Number:______________

Name:______________________ Relationship:______________ Phone Number:______________

Name:______________________ Relationship:______________ Phone Number:______________

Patient and/or Legal Guardian Signature______________________________ Date______________

☐Please check if you do not wish to release information to anyone other than yourself.

Consent for Treatment and/or Procedures:
I consent to medical treatment(s) and/or necessary procedures for the above patient. I understand that medical treatment(s) and/or procedure(s) will be discussed with me. I also understand I have the option to refuse any medical treatment(s) and/or procedure(s). Should I refuse advised medical treatment(s) or procedure(s) I consent to sign a refusal of treatment if applicable.

______________________________ ______________________ ______________
Signature of Patient/Legal Guardian Relationship to Patient Date

Family Convenience Clinic
Walk-in for minor illness or injury

2933 Cypress Street Ste 1
West Monroe, LA 71291

Patient Name______________________ Reason for visit today______________________

PATIENT PAST MEDICAL/SOCIAL/SURGICAL HISTORY

Past Medical History: Please check any or all conditions you have had in the past:

☐ AIDS
☐ Alcoholism
☐Anemia
☐Anorexia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bleeding Disorder
☐Breast Mass
☐Bronchitis
☐Cancer
☐Cataracts
☐Chicken Pox
☐Diabetes
☐Emphysema
☐Epilepsy
☐Glaucoma
☐Goiter
☐Gout
☐Heart Disease/Heart Attack
☐Hepatitis
☐Hernia
☐Herpes
☐High Cholesterol
☐HIV Positive
☐Hypertension
☐Kidney Disease
☐Liver Disease
☐Measles
☐Migraines
☐Miscarriage
☐Mononucleosis
☐Multiple Sclerosis
☐Mumps
☐Pacemaker
☐Pneumonia
☐Polio
☐Prostate Problems
☐Psychiatric Problems
☐Rheumatic Fever
☐Scarlet Fever
☐Sexually Transmitted Disease
☐Stroke
☐Suicide Attempt
☐Thyroid Problems
☐Tonsillitis
☐Tuberculosis
☐Ulcer - Stomach
☐Ulcer - Skin
☐Allergies______________
____
____

PAST SURGICAL HISTORY: Please list all past surgical procedures and the year of the procedure

☐Please check here if you have not had any surgical procedures

Procedure
____
____
____
____
____
____

Notes:

PAST FAMILY HISTORY Please check all that apply

If YOUR mother, father, siblings or grandparents have any of the following:

☐Arthritis
☐Cancer
☐Stroke
☐Kidney Disease
☐Diabetes
☐Heart Disease
☐Tuberculosis
☐High Blood Pressure
☐Other:______________
____
____
____
____

SOCIAL HISTORY:
Do you smoke:☐No never ☐Not now but I have in the past
☐Yes How many packs a day?__________
Do you drink alcohol?☐ No never ☐Yes How often?__________
Number of Pregnancies ____ Number of Abortions ____
Number of Live Births____ Number of Miscarriages____

Parents or Legal Guardians: Please complete the following Pediatric Social History

Home Environment:
Lives at home with: ☐Both Parents ☐Mom ☐Dad ☐Other__________
Smokers in house: ☐Yes ☐No
Guns in the house: ☐Yes ☐No
Do you have a pool: ☐Yes ☐No
Smoke detector in the house: ☐Yes ☐No
Pets: ☐Yes ☐No

Health Habits:
How often does your child exercise? ☐None ☐1-3 days ☐5-7 days
How much caffeine daily? ☐None ☐1-2 cokes/tea ☐3-4 cokes/tea ☐5 or more
How much TV/Video daily? ☐None ☐1-2 hours ☐3-4 hours ☐ >4 hours

School ______________________ Daycare ______________________

Grade level ☐Pre-School ☐Elementary ☐Middle ☐High School
Performance ☐ A's ☐ B's ☐ C's ☐ D's ☐ Failing

TEENS ONLY:
Tobacco use: ☐No ☐Yes How many packs per day____
Alcohol use: ☐No ☐Yes, how often __________
Drug use: ☐No ☐History of use ☐Current Use
Sexual history: ☐Not sexually active ☐Sexually Active

Notes:

My signature below indicates that all information completed on the Patient Information Form, Past and Current Medical/Social/Surgical/Family History is true and accurate to the best of my knowledge:

____
Signature of Patient / Legal Guardian Relationship Date