



**LOUISIANA WOMEN'S  
Healthcare Associates**

*Please Print*		<b>PATIENT INFORMATION FORM</b>				*Please Print*			
<i>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.</i>									
Doctor			Account No.			Date			
<b>PATIENT</b>  <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> 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		
	<b>RESPONSIBLE PARTY</b>  <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> 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: <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Another Physician <input type="checkbox"/> Web Site <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Advertisement									
<b>IN CASE OF EMERGENCY NOTIFY</b>	Name		Address			Relation		Phone	
<b>INSURANCE INFORMATION</b>	Type of Plan (Check One) <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> INDEMNITY <input type="checkbox"/> OTHER		Co-Pay Amount: _____		Type of Plan (Check One) <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> INDEMNITY <input type="checkbox"/> OTHER		Co-Pay Amount: _____		
	Primary Insurance				Secondary Insurance				
	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		
	<b>RELEASE OF INFORMATION &amp; FINANCIAL AGREEMENT</b>	<b>PLEASE BRING YOUR INSURANCE CARD TO EACH VISIT</b>							
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 LWHA. 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 _____									
<b>ACKNOWLEDGMENT OF PRIVACY PRACTICES</b>	I hereby acknowledge that I have been given the opportunity to review and receive a copy of LWHA's Notice of Privacy Practices. I would like to receive a copy of amended notices. <input type="checkbox"/> Yes <input type="checkbox"/> No Signed _____ Date _____								