BAYOUCLINIC, INC.

Patient Information

Name:_____ Race: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:_____ Social Security Number:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_____ City/State_____ ☐ FT ☐ PT

Responsible Party Name:_____ Relationship_____ Phone_____

Responsible Parties Address (if different than yours) _____

Person to contact in case of emergency_____ Phone_____

Family Size _____ Household Income (estimated):_____

Insurance Information (MAKE A COPY OF ALL INSURANCE INFO FOR CHART)

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Authorizations (PATIENT TO INITIAL BOXES AND SIGN CONSENT AT BOTTOM)

☐ **Authorization of Benefits to Provider:** I understand that I am financially responsible for all charges incurred at Bayouclinic, Inc. in relation to illnesses, injuries, and accidents. I hereby authorized Bayouclinic to furnish information to insurance carriers, and assign to Bayouclinic all payments for medical services rendered to me or my dependents. **I understand that I am responsible for any and all amounts not covered by insurance.** I further agree in the event of non-payment, to bear the cost of collection, and/or court costs and responsible legal fees should this be required.

☐ **Permission to Diagnose and Treat:** I voluntarily authorize and grant permission for the Bayouclinic provider to render such care that is deemed necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures, as well as obtain medical information/ records from other health care providers.

Date _____Signature _____ _____

Bayouclinic, Inc.

NEW PATIENT HISTORY

Please fill out the following sections as completely and accurately as possible so that we may provide the best quality of care.

Today's Date: _____ *Name:* _____ *Date of Birth:* _____

Previous Hospitalizations and Dates: _____

_____

PAST MEDICAL HISTORY (*Do you have/had any of the following?*):

- ☐ Alcohol dementia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bladder cancer
- ☐ Bleeding disease
- ☐ Breast cancer
- ☐ Bronchopulmonary infections (bronchitis)
- ☐ Cervical cancer
- ☐ Chest pain
- ☐ Congenital abnormalities (birth defects)
- ☐ Congestive heart failure
- ☐ Convulsions
- ☐ COPD
- ☐ Depression
- ☐ Diabetes melitus
- ☐ Esophageal cancer
- ☐ Heart (cardiac) disease
- ☐ Hepatitis (A)(B)(C) carrier
- ☐ Hepatitis exposure
- ☐ Hypertension (high blood pressure)
- ☐ HIV/AIDS or exposure to
- ☐ Hyperlipidemia
- ☐ Kidney cancer
- ☐ Kidney disease
- ☐ Laryngeal (throat) cancer
- ☐ Liver/stomach/bowel
- ☐ Lung cancer
- ☐ Migraine HA
- ☐ Obsessive Compulsive
- ☐ Parkinson's disease
- ☐ Prostate cancer
- ☐ Pulmonary embolism (Lung clots)
- ☐ Rectal cancer
- ☐ Reflux/GERD
- ☐ Schizophrenia
- ☐ Sexually transmitted disease
- ☐ Sinusitis
- ☐ Skin cancer
- ☐ Skin disease
- ☐ Testicular cancer
- ☐ Thrombophlebitis (leg clots)
- ☐ Thyroid cancer
- ☐ Thyroid disease
- ☐ TIA or Stroke
- ☐ Tuberculosis (TB)

Other:

_____

_____

SURGICAL HISTORY

- ☐ Abdominal
- ☐ Angioplasty
- ☐ Aortic aneurysm repair
- ☐ Appendectomy
- ☐ Arthroscopy knee
- ☐ Back surgery
- ☐ Bladder
- ☐ Breast biopsy
- ☐ Cardiothoracic
- ☐ Carpal tunnel
- ☐ Cataract/lens implant
- ☐ Cholecystectomy
- ☐ Colostomy, partial
- ☐ Coronary artery bypass graft
- ☐ Delivery by C-section
- ☐ Ears, nose, throat
- ☐ Gastric, other
- ☐ Gastroplasty, bariatric
- ☐ Hernia
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Intestinal bypass
- ☐ Joint replacement
- ☐ Kidney
- ☐ Laminectomy/ discectomy
- ☐ Lithotripsy
- ☐ Mastectomy
- ☐ Neurosurgery
- ☐ Oophorectomy
- ☐ Open lysis adhesions
- ☐ Orthopedic
- ☐ Prostate
- ☐ Skin/dermal
- ☐ Small bowel resection
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ TURP
- ☐ Ulcer

☐ Prior surgery **Other** - Explain:

_____

_____

_____

SOCIAL HISTORY

Occupation: _____

Living situation: ☐ w/ spouse ☐ alone ☐ w/ parents ☐ w/ children/family ☐ in nursing home ☐ other

Sexually active? ☐ Yes ☐ No **Birth control?** ☐ Yes (Type) _____ ☐ No **Condom Use?** ☐ Yes ☐ No

Habits: Sleep well? ☐ Yes ☐ No, reason _____

Practice preventive health? ☐ Yes ☐ No **Exercise:** ☐ Yes ☐ No If Yes, days/week _____

Leisure activities: ☐ Yes ☐ No If Yes, what? _____

Travel history: Where? _____ Method of travel: _____

Caffeine use: ☐ Coffee ____ cups/day ☐ Tea ____ cups/day ☐ Cola ____ cans/day
☐ Chocolate ____ bars/day ☐ Over the counter 'stay-awake' pills

Today's Date: _____ *Name:* _____ *Date of Birth:* _____

Alcohol Use: ☐ Never ☐ Prior heavy use ☐ Social
☐ Beer ☐ Wine ☐ Hard liquor Per day/week _____
☐ Considered quitting ☐ Angry discussing it ☐ Feel guilty using ☐ Use to "get going" in AM
☐ Use for symptom relief

Tobacco Use: ☐ Previous smoker ☐ Cigarettes: packs per day _____ ☐ Never smoked
☐ Chew tobacco ☐ Dip tobacco Age started _____ Age stopped _____

Drug Use: ☐ Marijuana ☐ Cocaine ☐ Intravenous ☐ Other _____ ☐ Never used ☐ No longer using

Diet: ☐ Taking meds to lose wt ☐ Taking vitamins ☐ Nutritious/Satisfying ☐ Needs improvement
☐ Recent change ☐ Vegetarian ☐ Other _____

Domestic Violence: Have you been physically or emotionally abused? ☐ Yes ☐ No
If yes, please briefly explain: _____

Any other information you would like us to know?

_____

_____

FAMILY HISTORY

Please check (√) all that apply

FAMILY HX	MOM	DAD	BRO.	SISTER	SON	DAUG.
Alcoholism						
Anemia						
Arthritis						
Asthma						
Backache						
Birth defects						
Bleeding problems						
Cancer						
Chronic disabling Dx						
Deafness before age 5						
Diabetes Mellitus						
Early deaths						
Genetic disease						
Goiter (simple)						
Heart attack						
Heart disease						
Hypertension (high blood pressure)						
Kidney disease						
Mental illness (not MR)						
Migraine headache						
Multiple births						
Polyps GI						
Stroke syndrome						
Thyroid syndrome						
Other:						

Mother's age: _____

Mother deceased at age: _____

Father's age: _____

Father deceased at age: _____

Were you provided with an **Advance Directive?** ☐ Yes ☐ No

If Yes, Date Provided: _____

Date Refused: _____

Drug Allergies:

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

_____

Bayouclinic, Inc.

♦♦♦

13833 Tapia Lane ♦ Bayou La Batre, AL 36509
Phone (251) 824-4985 ♦ Fax (251) 824-4990

PERMISSION TO GIVE MEDICAL INFORMATION

I_____ authorize the physicians and staff of BayouClinic, Inc. to give the following people information concerning my health and well being.

___Spouse/Significant Other Name_____

___Family Member Name_____

___Any Specified Person Name_____
(List names on back if more space needed)

Please check the following information that can be given to the above individuals.

_____Appointment times _____Test Results _____Medications

_____Procedures and other information regarding your health

You May:

____Yes____No Leave a message on answering machine.

____Yes____No Permission to call work place.

____Yes____No Permission to call your cell phone. (Not considered a secure line)

____Yes____No Permission to call emergency contact number.

I understand that I may revoke this consent at any time by giving written notice to the person or Organization making the disclosure.

____Yes____No I have received the Bayouclinic, Inc. Notice of Privacy Practices.

_____ _____
Signature of Patient/Legal Representative **Date**

_____ _____
Emergency Contact/Relationship **Phone Number**

Bayouclinic, Inc.

♦♦♦

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MEDICAL RECORDS AUTHORIZATION RELEASE OF HEALTH INFORMATION

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION, WHICH MAY INCLUDE: PSYCHOLOGICAL, DRUG OR ALCOHOL CONDITIONS AND/OR DIAGNOSIS, TREATMENT OR CARE FOR HIV OR SEXUALLY TRANSMITTED DISEASES.

I hereby authorize _____ **Phone** _____

Address _____ **Fax** _____

To release the following information from the medical record(s) of:

NAME _____

ADDRESS _____

PHONE NO. _____ **DATE BIRTH** _____

SOCIAL SECURITY NO. _____ **MR#** _____

Information to be released: Please Check

_____**Discharge Summary** _____**Treatment Plan** _____**History & Physical**

_____**X-Ray Reports** _____**Lab Reports** _____**OB/Gyn Reports** ____**Other(Specify)**_____

_____**Complete Record**

Purpose of Disclosures:

_____**Continued Patient Care** _____**Commercial Insurance** _____**Worker's Compensation**

_____**Attorney / Legal** _____**Personal Use** _____**Other(Specify)**_____

I understand this release may be revoked at any time except to the extent that action has been taken thereon. This authorization will expire on (1) year from the date of signature unless otherwise stated.

_____ **Date** _____

Patient or Legal Representative

If Legal Representative, state relationship to patient. _____ **Reason for signing** _____

Witnessed by: _____ **Date** _____

Note to Program/Agency receiving this information: This information has been disclosed to you from the records whose confidentiality is protected by Federal Law. Federal Regulations (42FR Part) prohibits you from making disclosure without the specific written consent of the person who it pertains to or as otherwise permitted by such regulations.