PATIENT INFORMATION

(Please PRINT)

Daniel Clinic Emp: _____

PATIENT:

LAST NAME _____ **FIRST NAME** _____ **MI** _____ **SUFFIX** _____

GENDER ☐ M ☐ F SSN _____ MARITAL STATUS ☐ S ☐ M DOB _____

RACE ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ OTHER

MAILING ADDRESS: _____ APT/LOT NO _____

PHYSICAL ADDRESS: _____

CITY _____ ST _____ ZIP _____

HOME PH _____ CELL PH _____ WORK PH _____ EXT _____

E-MAIL ADDRESS: _____

PREFERRED CONTACT METHOD ☐ PHONE ☐ MAIL ☐ E-MAIL

PREFERRED REMINDER METHOD ☐ HOME PH ☐ CELL PH ☐ WORK PH

DRIVER'S LICENCE NO _____ **ST** _____ **EXP DATE** _____

Emergency Contact Name_____ **Phone#**_____

INSURANCE:

POLICY HOLDER _____ **RELATIONSHIP TO PATIENT** _____

GENDER ☐ M ☐ F SSN _____ DOB _____

MAILING ADDRESS _____ APT/LOT NO _____

CITY _____ ST _____ ZIP _____

DRIVER'S LICENCE NO _____ ST _____ EXP DATE _____

AUTHORIZATION & RELEASE

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERMING MY (OR MY CHILD'S) HEALTH CARE, ADVICE AND TREATMENT PROVIDED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO DANIEL CLINIC FOR ANY FUNDS OTHERWISE PAYABLE TO ME.

X _____ ***DATE*** _____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR)

GUARANTOR: (Person Responsible For Payment)

NAME _____ **RELATIONSHIP TO PATIENT** _____

GENDER ☐ M ☐ F SSN _____ DOB _____

HOME PH _____ CELL PH _____ WORK PH _____ EXT _____

MAILING ADDRESS _____ APT/LOT NO _____

CITY _____ ST _____ ZIP _____

DRIVER'S LICENCE NO _____ ST _____ EXP DATE _____

X _____ ***DATE*** _____

SIGNATURE OF GUARANTOR

Health History

Patient Name_____ **Birthdate** _____/_____/_____

To help us meet all your healthcare needs, please fill out **both pages** of this form completely. This is a confidential record of your medical history and will be kept in this office

Today's date_____
Place of birth_____
Highest level of education_____
Occupation_____
Previous occupations_____
Marital Status_____
Hobbies_____
Exercise/recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last dental exam_____
Please list all allergies (foods, drugs, environment)
_____
_____
_____
Have you ever taken Fen-Phen/Redux? _____

When was your last physical exam? _____
Name of doctor_____ Phone # _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ None
_____
_____
_____
_____

Please list all medications you are currently taking (include nonprescription drugs): ☐ None
_____
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): ☐ None
_____
_____
_____

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:
_____
_____
_____

Past Medical History

Have you ever had the following: (Check "Yes" or "No" , leave blank if uncertain)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Measles	☐	☐	Epilepsy	☐	☐	Hives or Eczema	☐	☐
Mumps	☐	☐	Migraine headaches	☐	☐	AIDS or HIV+	☐	☐
Chickenpox	☐	☐	Tuberculosis	☐	☐	Infectious Mono	☐	☐
Whooping cough	☐	☐	Diabetes	☐	☐	Bronchitis	☐	☐
Scarlet Fever	☐	☐	Cancer	☐	☐	Mitral Valve Prolapse	☐	☐
Diphtheria	☐	☐	Polio	☐	☐	Stroke	☐	☐
Smallpox	☐	☐	Glaucoma	☐	☐	Hepatitis	☐	☐
Pneumonia	☐	☐	Hernia	☐	☐	Ulcer	☐	☐
Rheumatic Fever	☐	☐	Blood or Plasma transfusion	☐	☐	Kidney Disease	☐	☐
Heart Disease	☐	☐	Back trouble	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	High or low blood pressure	☐	☐	Bleeding Tendency	☐	☐
Venereal Disease	☐	☐	Hemorrhoids	☐	☐	Any other disease	☐	☐
Anemia	☐	☐	Asthma	☐	☐	(Please list)_____		
Bladder Infection	☐	☐	Date of last chest x-ray_____			_____		

Family History

Has any blood relatives had any of the following: (Check "Yes" or "No", leave blank if uncertain)

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Cancer	☐	☐	_____	Stroke	☐	☐	_____
Tuberculosis	☐	☐	_____	Epilepsy	☐	☐	_____
Diabetes	☐	☐	_____	Allergies	☐	☐	_____
Heart Disease	☐	☐	_____	Anemia	☐	☐	_____
High Blood Pressure	☐	☐	_____	Bleeding Tendency	☐	☐	_____

Health History

Family History (continued)
(Check "Yes" or "No", leave blank if uncertain)

Condition	Yes	No	Relationship
Asthma	☐	☐	
Chronic lung disease	☐	☐	
Drug or Alcohol problem	☐	☐	
Mental illness	☐	☐	
Leukemia	☐	☐	
Migraine Headaches	☐	☐	
Obesity	☐	☐	
Thyroid Disease	☐	☐	
Ulcer	☐	☐	
Depression	☐	☐	
High Cholesterol	☐	☐	
Kidney Disease	☐	☐	
Glaucoma	☐	☐	
Gout	☐	☐	

Present age (health-good,fair,poor)/Age of death (cause of death)

Father_____
Mother_____
Siblings_____
_____
_____
_____
_____
Spouse_____
Children_____
_____
_____
_____
_____
_____

Do you have now or have you had with the pas year: (Check "Yes" or "No", leave blank if uncertain)

Condition	Yes	No
Weakness or paralysis	☐	☐
Tire easily or weakness	☐	☐
Recent weight changes	☐	☐
Change in appetite	☐	☐
Sensitivity to cold or heat	☐	☐
Persistent fever	☐	☐
Night sweats or hot flashes	☐	☐
Skin rash	☐	☐
Skin trouble or changes	☐	☐
Change in nails or hair	☐	☐
Headaches	☐	☐
Easy bleeding or bruising	☐	☐
Double vision	☐	☐
Blurred vision	☐	☐
Eye pain	☐	☐
Infected eyes	☐	☐
Do you wear glasses/contacts	☐	☐
When was you last eye exam _____		
Ringing in the ears	☐	☐
Discharge from the ears	☐	☐
Ear pain	☐	☐
Decrease in hearing	☐	☐
Frequent nosebleeds	☐	☐
Frequent colds	☐	☐
Sinus trouble	☐	☐
Loss of smell	☐	☐
Persistent hoarseness	☐	☐
Sore throat	☐	☐
Sore tongue or gums	☐	☐
Lump or discharge for breast	☐	☐
A persistent cough/throat clearing not associated with known illness (lasting more than 3weeks)	☐	☐

Condition	Yes	No
Shortness of breath	☐	☐
Bloody sputum	☐	☐
Wheezing	☐	☐
Chest pain or discomfort	☐	☐
Purple fingers or lips	☐	☐
Swelling of hands, feet, ankles	☐	☐
Difficulty in breathing	☐	☐
Palpitations or fluttering of the heart	☐	☐
Leg cramps on walking or at night	☐	☐
Enlarge veins	☐	☐
Difficulty swallowing	☐	☐
Heartburn	☐	☐
Frequent belching	☐	☐
Abdominal cramping	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomited or coughed up blood	☐	☐
Chronic diarrhea	☐	☐
Chronic constipation	☐	☐
Rectal bleeding	☐	☐
Black tarry stools	☐	☐
Dark urine	☐	☐
Yellow jaundice	☐	☐
Frequent urination (day)	☐	☐
Frequent urination (night)	☐	☐
Increase in thirst	☐	☐
Painful urination	☐	☐
Leakage of urine	☐	☐
Difficulty in stating urine	☐	☐
Blood in urine	☐	☐
Lack of sex drive	☐	☐
Hemorrhoids	☐	☐
Backaches	☐	☐

Condition	Yes	No
Joint pain or stiffness	☐	☐
Swollen joints	☐	☐
Muscle cramps or spasms	☐	☐
Sleeplessness	☐	☐
Seizures	☐	☐
Depression	☐	☐
Memory loss	☐	☐
Poor coordination	☐	☐
Dizziness or fainting spells	☐	☐
A living will/advance directive	☐	☐
Men only:		
Discharge from penis	☐	☐
Pain or lump in testicles	☐	☐
Impotence	☐	☐
Women only:		
Age period began _____		
How many days do periods last_____		
How many days between periods_____		
Is the flow heavy?	☐	☐
Do you bleed or spot between periods?	☐	☐
Do you have pain or cramps?	☐	☐
Date of last period? _____		
Date of last pelvic exam? _____		
Date of last mammogram? _____		
Any itching in vaginal area?	☐	☐
Pain with intercourse?	☐	☐
Type of birth control? _____		
Number of pregnancies _____		
Number of full term births _____		
Number of preterm births _____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X_____ _____
Signature of Patient or Parent if Minor Date

_____
Physician's Signature

DANIEL CLINIC/WFPH PHYSICIAN CLINIC
5326 Oak Street / P.O. Box 487
Saint Francisville, LA 70775
Ph (225) 635-5848 Fax (225) 635-5847

Patient Name: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT

I consent to and authorize Daniel Clinic personnel to perform care and treatment including but not limited to medical treatment, laboratory, and/or diagnostic testing that may be ordered by said personnel.

I certify that I have read and understand the above authorization for medical treatment.

X_____
Signature of Patient (or Guardian)

ADVANCE DIRECTIVES

I have a Living Will ☐ Yes ☐ No
I have a Medical Power of Attorney ☐ Yes ☐ No

If Yes, I understand it is my responsibility to provide a copy for my medical records.

X_____
Signature of Patient (or Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of Daniel Clinic's Privacy Notice.

I understand that a privacy officer has been appointed and that any questions regarding that Privacy Act may be directed to the HIPAA Privacy Officer.

I have read and understand the facility's Privacy Notice. I understand that I have the right to restrict how my protected health information may be used. I also understand that the facility may refuse admission should the restrictions I place on my protected health information interfere 1) with the clinic's ability to treat and/or bill me for services rendered or 2) with the operations of the facility.

X_____
Signature of Patient (or Guardian)

DANIEL CLINIC
5326 Oak Street / P. O. Box 487
Saint Francisville, LA 70775
Phone (225) 635-5848 Fax (225) 635-5847

RECORDS OVER 25 PAGES SHOULD BE MAILED

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name	DOB	SSN
Guardian's Name (if patient is a minor)	DOB	SSN

This authorization shall expire on: _____ If I fail to specify an expiration date, this authorization will expire six (6) months from the date on which it was signed.

Purpose of disclosure:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

Description of Information to be used or disclosed:

☐ Complete Medical Information ☐ Clinic Visit Information ☐Lab work/Radiology

☐ Verbal Information ☐ Other _____

Information may be released **from**:

Name of Dr.(*First & Last Name*)**/Clinic**

_____

Address

_____

_____

Phone Number(*Please Provide*)

_____

Fax Number

_____

Information may be released **to**:

DANIEL CLINIC

☐ Dr. Chaillie Daniel ☐ Dr. Timothy Lindsey

☐DewanaBobo ☐ Patty Hayden

☐ Rachel Simmons ☐ Dawn Hanna

☐KamerynFevella

I acknowledge, and hereby consent to such, that the released information may contain genetic test results, alcohol/drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ **(initial)**

I understand that:

1) I may refuse to sign this authorization and that it is strictly voluntary.
2) If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3) I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4) If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5) I understand that I may see and obtain a copy of the information described on this form if I ask for it.
6) I may get a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

***Printed* Name of Patient**_____

Printed Name of Guardian(if minor) _____

Relationship to Patient _____

***Signature* of Patient/Guardian** _____

Witness Signature _____ Date _____