Primary Care Plus
Your doctors for life

primarycareplus.com

Welcome to Primary Care Plus/Lafayette

Thank you for putting your trust in Primary Care Plus for your healthcare needs. We would like to take this opportunity to welcome you to our practice and look forward to providing you with personalized, comprehensive health care.

Having the most current information is essential in meeting your healthcare needs. We would appreciate your assistance in updating your medical record by completing the forms listed below:

- **Patient Information Form -** provides your physician with thorough knowledge of your current health issues, an accurate medication list, and a family medical history. Also includes your current contact information (phone number, email, text) so we can reach you regarding your healthcare.

- **Responsibility for Payment and Receipt of HIPAA Notice Form** – allows us to bill your insurance company for services provided to you and acknowledges you have received the Notice of Privacy Practices.

- **Consent for Treatment Form -** gives our medical staff permission to provide basic evaluation and treatment of your medical conditions.

- **Designation of Personal Representative Form** - grants a family member or friend permission to discuss medical or billing information on your behalf. Written permission is needed for us to discuss any aspect of your care with anyone else.

- **Authorization for Release of Protected Health Information**-allows us to obtain your medical records from other healthcare providers.

An important part of each visit with your doctor is reviewing all medications you are currently taking from ALL providers - both primary care and specialists. Please bring all medications with you to every visit.

Primary Care Plus is recognized as a Patient Centered Medical Home which is a reflection of our commitment to providing the highest quality care for our patients. We provide proactive care to promote wellness and prevent illness and will be communicating with you by telephone, text message (with your permission) and our patient portal. Please be sure to provide current contact information on the *Patient Information Form*.

As a patient of Primary Care Plus, we are committed to helping you *be well and enjoy life to the fullest.* Please review the additional information about Primary Care Plus that is in this folder. Should you have any questions or comments, please do not hesitate to contact me directly at **(337) 895-6000.**

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Referred by: __Family __Friend __Internet __TV __Radio __Mail __Social Media TODAY'S DATE: _____

Patient Information Form (Please Print)

	Primary Care Physician:	**Have you been a patient of Primary Care Plus or Stanocola in the past?** ☐ Yes ☐ No

PATIENT

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

Last	**First**	**MI**	**Date of Birth**	**Age**
Address		**City**	**State**	**Zip**
Social Security #: _____		**Sex:** ☐Male ☐Female	**Are you retired?** ☐Yes ☐No	
Street Address (if different from mailing)		**City**	**State**	**Zip**
Phone (Home)	**Name of Employer**		**Employer's Phone #**	
Phone (Mobile)	**Employer's Address**			

Preferred Method of Contact? ☐Home Phone ☐Cell Phone
May we send appointment and treatment reminders via text and voicemail? ☐Yes ☐No

Email:

Spouse's Name	**Date of Birth**

ADDITIONAL INFORMATION

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific ☐Black ☐White ☐Hispanic ☐Other ☐Decline to Answer

Ethnicity: ☐Hispanic ☐Non-Hispanic | What Language do you prefer? ☐English ☐Spanish

Name of your Pharmacy		**Address**	
City	**State**	**Zip**	**Phone #**

RESPONSIBLE PARTY

☐ Self
☐ Spouse
☐ Guardian
☐ Other

Last	**First**	**MI**	**Phone Number:**
Address			
City		**State**	**Zip**

IN CASE OF EMERGENCY NOTIFY

Name	**Relation**
Address	**Phone #**

INSURANCE INFORMATION

Primary Insurance		**Address**	
Policy Contract #	**Group #**	**City**	**State** **Zip**
Name of Policy Holder		**Date of Birth**	
Secondary Insurance		**Address**	
Policy Contract #	**Group #**	**City**	**State** **Zip**
Name of Policy Holder		**Date of Birth**	

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Date: _____

Patient's Name: _____ Guardian's Name (if under 18): _____

LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

Name	Dose	Frequency	Ordering Provider

YOUR HEALTH HISTORY

(Check if you have had any of the following)

	Abnormal Heart Rhythm		Chronic Pain		Heartburn/GERD		Obesity
	Allergies (any)		Chronic Kidney Disease		Heart Murmur		Osteoporosis
	Anemia		Depression		Hepatitis		Peripheral Vascular Disease
	Anxiety/Stress		Diabetes		High Blood Pressure		Seizures/Epilepsy
	Asthma		Emphysema/COPD		High Cholesterol		Sleep Apnea
	Arthritis		Gallbladder Disease		HIV/AIDS		Stomach Ulcers
	Atrial Fibrillation		Gout		Irritable Bowel Syndrome		Stroke
	Colitis or Crohn's Disease		Headaches/Migraines		Kidney Failure		Thyroid Disease
	Cancer		Heart Attack/Failure		Kidney Stones		

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

Medication or Other (Environmental)	Reaction

OB/GYN HISTORY

Number of Pregnancies		Number of abortions/miscarriages	
Number of full-term babies		Number of living children	
Number of premature babies			

PAST SURGICAL HISTORY

Date	Surgery	Date	Surgery

Please List Any Additional Medical Information:

_____

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Sibling(s)
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									

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Date: _____

Patient's Name: _____ Guardian's Name (if under 18):_____

FAMILY HISTORY - CONTINUED

(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Sibling(s)
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

Relationship	Cause of death	Age at death	Relationship	Cause of death	Age at death

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ___ How many packs per day? ___

Did you quit? YES NO (circle one) If yes, what year did you quit? _____

How many alcoholic beverages do you drink per week? _____ How many days per week do you exercise? _____

In the past 6 months, have you had a regular problem with pain? YES NO Where? _____

Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

Device	Yes/No	Device	Yes/No	Device	Yes/No
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

_____

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician	Vaccine Type	Date
Colonoscopy				Tetanus (Td)	
Cholesterol Screening				Pneumonia	
Cardiac Stress Test				Hepatitis B	
Bone Density				Influenza (Flu)	
Mammogram				Shingles	
Breast Exam				Other	

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

Specialty	Physician	Specialty	Physician	Specialty	Physician
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? **YES NO (circle one)**

If yes, please supply the office with a copy for your chart. If no, would you like one? **YES NO (circle one)**

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? **YES NO** Do you have any metal pins/plates in your body? **YES NO If yes, please describe:**

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Handling your health with care

Consent for Treatment

I, _____, am voluntarily seeking healthcare and hereby consent
(Patient's name)
to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general , to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending physician or other physicians assisting in my care.

The consent given shall be valid and binding and the physician(s) can rely on this authorization and accept any consent given by the patient until such time as physician receives written notice that the authorization is revoked.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient or Legal Representative Relationship

_____
Date

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Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I,_____ Date of Birth_____(print name and date of birth) hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involving the use and/or disclosure of health information that pertains to me.

Name of Personal Representative(s)	Relationship To Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The Authority of this person when serving as my "personal representative" is restricted to the following functions:

Description:

☐ This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

☐ This person is restricted to the following information about my health care:

_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to:

Primary Care Plus - Lafayette
318 Guilbeau Rd.
Lafayette, LA 70506
Attention: Clinic Manager

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____

Signature Date

REVOCATION SECTION:

I hereby revoke the designation of _____ as my personal representative.

_____

Patient Signature Date

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Authorization for the Release of Protected Health Information (PHI)

Patient Name (Last, First, Middle): _____ Date of Birth: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip code: _____

Contact Phone Number(s): _____

I hereby authorize the following entity to release the Protected Health Information (PHI) below to:
Primary Care Plus, 318 Guilbeau Rd., Lafayette, LA 70506
Attention: Administration: Telephone: (337) 895-6000 Fax: (337) 895-6024

Entity Possessing the PHI: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number(s): _____ Fax: _____

If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.

PHI and Dates of PHI Authorized for Use of Disclosure

Description	Start & End Date of PHI	Description	Start & End Date of PHI
[ ] All PHI Records	_____	[ ] History & Physical Exam	_____
[ ] Laboratory Test	_____	[ ] X-Ray Tests/Reports	_____
[ ] Progress Notes	_____	[ ] Discharge Summary	_____
[ ] Consultation Reports	_____	[ ] Itemized Billing Statement	_____

[ ] Other _____

****The following information will be released unless you indicate DO NOT RELEASE by checking the appropriate box**

[ ] AIDS/HIV OR STD treatment [ ] Psychiatric/Mental Care [ ] Alcohol/Drug/Substance Abuse [ ] Genetic Screening

Other, please specify: _____

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment of eligibility of benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor 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 disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Primary Care Plus

Signature of Patient or Patient's Representative (if applicable): _____ Date: _____

Personal Representative's Relationship to Patient and Description of Authority to Act: _____