DEMOGRAPHICS INTAKE FORM

Hebert Medical Group, APMC

LOC: EU JE LA OE AE AJ AS PT

Acct #: ______ ☐ ABN Form ☐ Accident/Injury Information Form Completed Date: ______

P-INS Code: ______ S-INS Code: ______ F/C: ______ ☐ Request for Confidential Communications Attached

PATIENT INFORMATION

Prefix: Mr./Mrs./Other: ______ Patient*⇳: ______ Last ______ First ______ Middle

Suffix: Jr./Sr./Other: ______ Previous Name: ______

Mailing Address: ______ (If PO Box, complete Street Address Below) ______ City ______ State ______ Zip

Street Address: ______ ______ City ______ State ______ Zip

Home #: ______ Cell #: ______ Work #: ______ Ext: ______

Circle the preferred phone #/email contact. Leave message at what phone number? ☐ Home ☐ Work ☐ Cell ☐ None

Email: ______

Date of Birth*: ______ Marital Status*: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Social Security#: ______

Employer: ______ Occupation: ______

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ______ MMDDYY ☐ Military Active ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A Patient & Responsible Party are the same*? ☐ Yes ☐ No (complete below)

Race*: ☐ African American ☐ Caucasian/White ☐ Other: ______

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language*: ☐ English ☐ Spanish ☐ Other: ______

☐ Provide copy of insurance card(s) to be scanned⇳ (if not, complete below) Do you have well care/preventative coverage for annual exams: ☐ Yes ☐ No

Primary Insurance: ______ Secondary Insurance: ______

Primary Ins Policy #: ______ Secondary Ins Policy #: ______

Group #: ______ Group #: ______

Policy Holder's Name: ______ DOB: ______ SS#: ______

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT (NOT SELF), THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Prefix: Mr./Mrs./Other: ______ Responsible Party: ______ Last ______ First ______ Middle (Employer Info if work related)

Suffix: Jr./Sr./Other: ______ Relationship to Patient: ______ Social Security #: ______

Mailing Address: ______ (If PO Box, complete Street Address Below) ______ City ______ State ______ Zip

Street Address: ______ ______ City ______ State ______ Zip

Home #: ______ Cell #: ______ Work #: ______ Ext: ______

Date of Birth*: ______ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Email: ______ Preferred Language: ☐ English ☐ Spanish ☐ Other: ______

Employer: ______

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Retired ☐ Military Active ☐ Not Employed

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☐ Request for Confidential Communications Attached

Patient Name: ______________________ Date of Birth: ____________

How were you referred to our practice: ☐ Friend/Relative ☐ Newspaper ☐ Radio ☐ Healthsource ☐ Other: ____________

☐ Referred Physician: ______________________ Phone #: ____________

Primary Care Provider (PCP): ____________ Address: ____________ Phone: ____________

Is this an Accident or Injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

If 'Yes' to either question, request and complete an Accident/Injury Information Form (Rec'd by): (Date):

Do you have an Advanced Directive (living will, durable power of attorney)? ☐ Yes ☐ No

If 'Yes', provide copy. Rec'd by: Date:

Are you or have you been incarcerated within the last year? ☐ Yes ☐ No

If 'Yes', please provide: Facility Name: ______________________ Release Date: ____________

By signing this form, I hereby acknowledge Hebert Medical Group (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

If below is not signed by the patient, please indicate relationship:

☐ Parent or Guardian of minor patient; ☐ Power of Attorney, Turix, Curator or Designated Personal Representative

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________ (Initial) I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of HEBERT MEDICAL GROUP, APMC.
Acknowledgement refused:
Efforts to obtain: ______________________
Reason for refusal: ______________________

________ (Initial) I hereby acknowledge I have been provided with, read and understand the practice's 'No Show' policy and I understand that I will be charged the current fee for each no show appointment.

________ (Initial) I hereby authorize Hebert Medical Group to evaluate and recommend any testing and/or additional treatment from other facilities, i.e., labs; who will in turn bill me for their services. I understand I have the right to refuse any such recommendations/treatment.

________ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility.
I verify all above information is true and accurate as of the below indicated date.

________ (Initial) I hereby authorize the listed insurance companies to pay directly to Hebert Medical Group benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance, i.e., my Out of Pocket (OOP) share.

________ (Initial) I understand that any payment(s) made by me to Hebert Medical Group in the form of a check may be processed as an electronic check transaction; therefore, the funds will be debited immediately from my checking account.

________ (Initial) I agree that Hebert Medical Group may contact me via any means that I have provided on the prior page of this form including but not limited to land lines, cell phones (text and mobile applications), and email, etc.

______________________ ____________
Signature ☐ Patient ☐ Responsible Party Date

OFFICE USE ONLY Provide ABN for all potentially non covered services

HMG Staff: Scan to patient demographics 'eCW/INS' folder with copy of Insurance Card/Birth Certificate/Drivers License.

** = Required for eCW ⇄ = Interfaces to MEDPM*

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Patient Name: ______________________________ Date of Birth: ____________

EMERGENCY CONTACT: ______________________________ Relationship: ____________

Home #: ____________ Cell #: ____________ Work #: ____________ Ext: ______

Email: ______________________________

Any special instructions: ______________________________

____

____

____

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', office staff to assist in completing a Hospice/HHA/NH/SNF Facility Information Form.

☐ Hospice/HHA/NH/SNF Facility Info Form

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

*Note: If request initiated, assign Account Status: R - HIPAA Restricted (in **MEDPM**); send copy to MEDDATA.*

Please list any person(s) other than yourself, and their relationship to you, that we may discuss your medical information with:

Person:	Relation:	Phone #:
1)		
2)		
3)		
4)		
5)		

Signature: ______________________________ Date: ____________

DONALD W. BARNES, JR. MD

GYN HISTORY

Date________________

Name ______________________________ D.O.B________________
Occupation ______________________________
Referred By:______________________________
Reason for visit:______________________________

PREGNANCY HISTORY

Times Pregnant_____ Premature Births_____ Living Children ______ Abortions_______
Miscarriages_______

Please fill out the following if you are pregnant:

Order of Birth	Date (mo/yr)	Weight/Sex	Type of Delivery	Hospital	Problems

MENSTRUAL/ SEXUAL HISTORY

Age of onset of periods_______ Date of Last Period_________
Periods are: ☐ REGULAR ☐ IRREGULAR
Age at first intercourse______
Three or more sexual partners_______
Painful intercourse________
Last Pap/Result____________________ Last Mammogram/Result______________

CONTRACEPTION

	Past	Present
Birth Control Pills	____________	____________
Diaphragm	____________	____________
IUD	____________	____________
Foam/Condoms	____________	____________

PAST MEDICAL HISTORY (please list all medical problems: Diabetes, high blood pressure, etc.)

____
____
____

MEDICATIONS (please list name and dose)

____
____
____
____
____
____

ALLERGIES ☐ Yes (please list below) ☐ No

____

____

PAST SURGICAL HISTORY (please list and date)

____

____

____

____

SOCIAL HISTORY

Marital Status________________

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever used drugs? ☐ Yes ☐ No

FAMILY HISTORY	Age (if living)	Age at Death	Cause/ Med Problems
Father			
Mother			
Siblings			

Please check any of the following in you or your family:

- ☐ Breast Cancer________________
- ☐ Ovarian Cancer________________
- ☐ Colon Cancer________________
- ☐ Heart Disease________________
- ☐ Diabetes________________
- ☐ High blood pressure________________
- ☐ High Cholesterol________________

REVIEW OF SYSTEMS (Please circle the number of any condition you may have or have had in the past)

1. SEIZURE or CONVULSIVE DISORDER
2. SEVERE HEADACHES or FREQUENT ONES
3. UNUSUAL SKIN LESIONS, HAIR GROWTH or LOSS
4. HEART MURMUR or RHEUMATIC FEVER
5. IRREGULAR or FAST HEARTBEAT
6. STOMACH, BOWEL, or GALLBLADDER TROUBLE
7. RECURRENT CONSTIPATION or DIARRHEA
8. RECTAL BLEEDING or BLOOD IN STOOLS
9. BLADDER INFECTIONS or BURNING WITH URINATION
10. KIDNEY INFECTION
11. BLOOD CLOT IN LEGS OR LUNG
12. FREQUENT FEELINGS OF NERVOUSNESS, LONELINESS, DEPRESSION
13. CONCERN OVER WORK or FAMILY PROBLEMS
14. TROUBLE SLEEPING
15. HAD GONORRHEA, PELVIC INFECTION, or GENITAL WARTS
16. HAD HERPES
17. HAD AN ABNORMAL PAP SMEAR
18. VISUAL PROBLEMS or WEAR CORRECTIVE GLASSES
19. LIVER DISEASE

Patient Signature:____

DONALD W. BARNES, JR. MD
OBSTETRICS & GYNECOLOGY

PHONE 337/550-3740
FAX 337/550-3742

DATE:________________

RE: Consent for minors privacy

I DO or I DO NOT permit Dr. Barnes (or his nurse) to disclose my health information to anyone, other than myself.

I, ___________________________, give permission to Dr. Barnes (or the nurse) to disclose my health information to ____________________________. This includes, but is not limited to, pregnancy tests, sexually transmitted diseases results, pap smear results, biopsy results.

Patient's signature___________________________________

Witness: ______________________________

3521 HWY. 190. SUITE W • EUNICE, LOUISIANA 70535

Donald W. Barnes, Jr., M.D.
Obstetrics/Gynecology
3521 Hwy 190 Suite W
Eunice, La. 70535
Phone: (337)550-3740 Fax: (337)550-3742
Toll Free: 866-228-8522

Authorization for Release of Medical Records

This is to authorize every physician , hospital, or medical facility to release my medical records including but not limited to lab reports, x-ray reports, x-ray films, HIV testing, and hospital records concerning any medical findings and treatment such as Rape, Molestation,or Mental Illness, to Dr. Donald Barnes, Jr. M.D.
Please release these records to Dr. Barnes upon his request.

Your prompt attention to this authorization and request for all medical records will be highly appreciated.
If you have any questions, please do not hesitate to contact Dr. Barnes office.

Patient's Name: ______________________________

Date of Birth: ______________________________

Social Security # : ______________________________

Signature of Patient: ______________________________

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Hebert Medical Group, APMC reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

______________________________ ____________________

Printed Name Date

____

Signature