THIBODAUX SURGICAL SPECIALISTS
PATIENT INFORMATION

PLEASE PRINT

MR. MRS. MISS MS.

PATIENT NAME ______________________ DATE OF BIRTH ______________ AGE_____

SS# ______________ HOME PHONE ______________ CELL PHONE ______________
MAILING ADDRESS ______________________ CITY ______________ ZIP __________
PHYSICAL ADDRESS (IF DIFFERENT) ______________________
E-MAIL (IF YOU WOULD LIKE ONLINE ACCESS TO YOUR MEDICAL HISTORY) ______________ @ __________

RACE ______________ ETHNICITY ______________ (HISPANIC/LATINO() NON HISPANIC/LATINO()

PATIENT EMPLOYER ______________________ OCCUPATION ______________
WORK PHONE ______________
NAME OF POLICY HOLDER ______________________ DATE OF BIRTH ______________
RELATIONSHIP TO PATIENT ______________ S/S# ______________
IS PATIENT A STUDENT: ()YES ()NO ()FULL TIME OR () PART TIME

WHO IS YOUR PRIMARY CARE PHYSICIAN ______________________
WHAT PHYSICIAN REFERRED YOU TO OUR PRACTICE ______________________

EMERGENCY CONTACT INFORMATION:
NAME ______________________ RELATIONSHIP ______________
ADDRESS ______________________ PHONE ______________

PREFERRED PHARMACY ______________________
PHARMACY ADDRESS OR LOCATION ______________________ PHONE ______________

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. AS OUTLINED IN OUR NOTCE. THE TERMS OF OUR NOTICE MAY CHANGE. IF OUR NOTICE IS CHANGED OR MODIFIED YOU MAY OBTAIN A REVISED COPY BY REQUEST FROM US.

YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PROTECTED HEALTH INFORMATION ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. WE ARE NOT REQUIRED TO AGREE TO THIS RESTRICTION, BUT IF WE DO, WE ARE BOUND BY OUR AGREEMENT. BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED OF PROTECTED HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING, EXCEPT WHERE WE HAVE ALREADY MADE DISCLOSURES IN RELIANCE ON YOU PRIOR CONSENT, THIS CONSENT IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. ANY AND ALL RECORDS, WHETHER WRITTEN OR ORAL OR IN ELECTRONIC FORMAT ARE CONFIDENTIAL AND CANNOT BE DISCLOSED WITHOUT MY PRIOR WRITTEB AUTHORIZATION, EXCEPT AS OTHERWISE PROVIDED BY LAW
2. A PHOTOCOPY OR FAX OF THIS CONSENT IS AS VALID AS THE ORGINAL
3. I MAY REVOKE THIS CONSENT AT ANY TIME, EXCEPT WHERE INFORMATION HAS ALREADY BEEN RELEASED. THIS CONSENT IS VALID UNTIL REVOKED BY ME IN WRITING.

SIGNATURE ______________________ DATE ______________________

THANK YOU FOR CHOOSING THIBODAUX SURGICAL SPECIALISTS

NAME ______________________________

NEW PATIENT YES NO

DOCTOR WHO REFERRED YOU ________________________________

DO YOU SMOKE : PREVIOUSLY CURRENTLY NEVER

MEDICATIONS

Do you take any herbs? Yes No List: ____

Please list all medications, including non-prescription medications:

____

____

____

____

____

____

____

____

ALLERGIES

____

____

THIBODAUX SURGICAL SPECIALISTS

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES FORM

I am a patient of Thibodaux Surgical Specialists (TSS) and I hereby acknowledge receipt of their Notice of Privacy Practices.

Date:______________________________

Patient name____

Signature of patient____

or

Parent or legal guardian signature____