LOUISIANA HEALTHCARE ASSOCIATES, LLC.

71207 Highway 21
Covington, LA. 70433
Phone: (985)892-6811
Fax: (985)892-8767

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Referred By:	**PCP:**

PATIENT INFORMATION

Email:				
Name: (Last)	**(First)**	**(Middle)**	**Birthdate:**	**Sex:** M F
Address / P.O. Box, City, State, Zip Code:				
Social Security Number:	**Home Phone Number:**		**Cell Phone Number:**	
Employer:	**Employer Phone Number:**			

INSURANCE INFORMATION

Responsible Party Information (if different from above)

Person Responsible for Bill:	**Birth Date:**	**Address (if different):**	**Home Phone Number:**
Employer:		**Employer Address:**	**Employer Phone Number:**

Name of Primary Insurance:				
Subscriber's Name:	**Subscriber's S.S. Number:**	**Birth Date:**	**Group Number:**	**Policy Number:**
Patient's Relationship to Subscriber:				

Name of Secondary Insurance (if applicable):	**Subscriber's Name:**	**Group Number:**	**Policy Number:**
Patient's Relationship to Subscriber:			

IN CASE OF EMERGENCY

Name of Emergency Contact:	**Home Phone Number:**	**Work Phone Number:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hewlett-Packard or insurance company to release any information required to process my claims.

X **X**

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Date: _____

Patient Name: _____ DOB: _____ Age: _____ Sex: _____

Reason for Visit: _____ Race: _____ Ethnicity: _____

Drug or Food Allergies/ Reaction:	Primary Care Physician: Cardiologist:

Current Medications:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all previous surgeries with date:

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS – Do you have a history of the following medical problems?

NO	YES		NO	YES	
____	____	High Blood Pressure	____	____	Anemia/ Easy Bruising/ Free Bleeding
____	____	Chest Pain/Shortness of Breath	____	____	Sickle Cell/ Other Blood Disease
____	____	Heart Attack/ Heart Murmur	____	____	DVT
____	____	Pacemaker/ AICD	____	____	Epilepsy, Seizures
____	____	Irregular Heart Beat/ Other Heart Disease	____	____	Fainting or Dizziness
____	____	Asthma/ Bronchitis	____	____	Stroke, Paralysis, Other Neuro Disorder
____	____	Emphysema/ Other Lung Disease	____	____	Depression, Anxiety, Psych Disorder
____	____	Limited Neck Motion, Pain or Injury	____	____	Back Problems/ Arthritis/ Swelling
____	____	Jaw Clicking, Pain or Stiffness	____	____	Thyroid Problems/ Goiter
____	____	Facial Plastic or Reconstructive Surgery	____	____	Eye Disease
____	____	Hepatitis, Jaundice or Liver Disease	____	____	Recent Cough, Cold, or Flu
____	____	Nausea/ Vomiting	____	____	Headaches or Recent Visual Changes
____	____	Indigestion/ Ulcers/ Reflux/ Hiatal Hernia	____	____	Immunosuppression/ Chemotherapy
____	____	Kidney Disease	____	____	Do you sleep on 2 or more pillows?
____	____	Diabetes Mellitus	____	____	Sleep Apnea – CPAP? _____
____	____	History of Falls	____	____	Cancer – Type _____
____	____	Any type of Implant _____			

SOCIAL HISTORY Circle all that applies

Do/ Did you smoke? NO YES QUIT Packs Per Day _____ How Many Years? _____ If Quit When? _____

Caffeine Consumption: COFFEE TEA SODAS ENGERY DRINKS TABLETS How many per day? _____

Alcohol Consumption: BEER WINE LIQUOR How many drinks? _____/ per DAY WEEK MONTH SOCIALLY

LOUISIANA HEALTHCARE ASSOCIATES, LLC

Sunil K. Purohit, M.D., F.A.C.S.
Joshua P. Sleeper, M.D.

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Covington, LA. 70433

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With your consent, **Louisiana Healthcare Associates, LLC** may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office manager at 71207Highway 21, Covington, LA. 70433

With your consent, **Louisiana Healthcare Associates, LLC** may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any calls pertaining to your clinical care.

With your consent, **Louisiana Healthcare Associates, LLC** may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and healthcare operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and healthcare options. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent we may decline to provide treatment for you.

Name of person or persons we have permission to discuss your medical care and financial responsibility with

_____/_____/_____
NAME RELATIONSHIP PHONE NUMBER
_____/_____/_____
NAME RELATIONSHIP PHONE NUMBER
_____/_____/_____
NAME RELATIONSHIP PHONE NUMBER

Print Patient's Name: _____Date: ____/____/_____

Signature of Patient or Legal Guardian:_____