OUR LADY OF THE LAKE PHYSICIAN GROUP

Patient Information Sheet - Pediatrics

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Patient Information

MRN (Epic) _____

Name _____ Social Security # _____ Sex: M F
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

Parish _____

Preferred contact number: (circle one) Home Work Mobile
Would you like to receive text message (SMS) appointment reminders? Yes ☐ No ☐

Home phone _____ Work phone _____ Mobile phone _____

Email address _____ Language ☐ English ☐ Spanish ☐ Other _____

Primary Care Physician (PCP) _____ Referring MD (if different than PCP) _____

Person outside of household to contact in case of emergency or in case we must reschedule an appointment for you.

Name _____ Phone #'s _____ Relationship _____

Marital Status: (circle one)
Married
Legally Separated
Widowed
Unknown
Divorced
Single
Significant Other
Other

Ethnicity: (circle one)
Hispanic or Latino
Not Hispanic or Latino
Unknown
No Answer

Race: (circle one)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White or Caucasian

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Responsible Party Information (If different from patient)

Mother/Guardian			Father		
	Last	First M.I.		Last	First M.I.
Mailing Address			Mailing Address		
City/State/Zip			City/State/Zip		
Parish			Parish		
Home/Cell Phone			Home/Cell Phone		
Date of Birth			Date of Birth		
Social Security #			Social Security #		

Employer (Responsible party if patient is a child) _____

Employer address _____ _____ _____ _____
City State Zip

Employer phone _____

1/4/2016

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

Policy Holder Information (if different from patient and responsible party)

Name _____ Social Security # _____ Sex: M F
Last First Middle

Date of Birth _____ other known name(s) _____

Mailing Address _____ _____ _____ _____
City State Zip

Parish _____ Relationship to patient _____

Home phone _____ Work phone _____ Mobile phone _____

Employer _____

Employer address _____ _____ _____ _____
City State Zip

Employer phone _____

Employment Status: (circle one) disabled full time part time not employed on active military duty retired
Self-employed student full-time student part-time unknown

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Insurance Information

(Primary Coverage)

Insurance Company _____

Ins Address _____

City _____ State _____

Zip _____ Phone _____

Relationship to Patient _____

Insurance ID # _____

Effective Date _____

Group # _____

Name on Card _____

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other _____

(Secondary/Supplemental Coverage)

Insurance Company _____

Insurance Address _____

City _____ State _____

Zip _____ Phone _____

Relationship to Patient _____

Insurance ID# _____

Effective Date _____

Group # _____

Name on Card _____

Covered Through: (circle one) current employer retirement
Cobra/continuation of benefits
Other _____

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By initialing next to each item below, then signing my name at the bottom of this form, I agree to the following:

_____ I hereby acknowledge that I have read and fully understand the terms and provisions set forth in Our Lady of the Lake Physician Group, LLC's General Consent for Treatment form, including, but not limited to, the sections pertaining to consent to treatment, Medical Education, the use of Photography and Other Recordings, and the Authorization for Healthcare Related Calls, Texts and E-mails. In accordance with the General Consent for Treatment form, I do hereby consent to and authorize treatment by the physicians, physician assistants, nurse practitioners, resident physicians, fellows, health care students, therapists, interns, nurses, and any other clinical staff of Our Lady of the Lake Physician Group, LLC and certain outpatient departments of Our Lady of the Lake Hospital, Inc.

_____ I agree to pay for all financial obligations and abide by the terms and provisions of the Financial, Cancellation and Dismissal Policy and Patient Responsibilities form of Our Lady of the Lake Physician Group, LLC, which I acknowledge that I have read and fully understand, including the sections pertaining to Payment Guarantee and Insurance Authorization/Assignment of Insurance Benefits, Precertification, 24-Hour Cancellation policy, Termination of Physician-Patient Relationship policy, Other Physician Charges and Medical Records Copying Fees.

Print Name: _____ Signature of Patient: _____ Time: _____ Date: _____

Legal Guardian: _____ Signature of Legal Guardian: _____Time: _____ Date: _____