EBW Clinic

Elizabeth B. White, MD

PATIENT INFORMATION

Last Name: _____ Prefix: ___Suffix: ____

First Name: _____ MI _____

Maiden Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State: ____ Zip: _____

Hm Phone: ____ - _____ - _____ Cell: ____ - _____ - _____

Work Phone: Ext.: _____

DOB: ___ /___ /____ Age: _____ Sex: ☐ M ☐ F

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security: ____ - _____ - _____

Race: _____ Ethnicity: _____

Employer Name: _____

Employer Address: _____

City_____ State_____ Zip _____

Emp Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disabled

Student Status: ☐Full-Time ☐ Part-Time ☐ Not Applicable

Emergency Contact: _____
Relationship: _____
Phone: ____ - _____ - _____

Patient Email: _____

Would you like to enroll in the online patient portal?

☐ Yes ☐ No

If needed, can we:

Leave Message? Home: ☐ Yes ☐ No Cell: ☐ Yes ☐ No

Pharmacy Name: _____

Address: _____

Phone: _____ - _____ - _____

Responsible Party (name):_____

Relationship: _____

Insurance: Name: _____

Policy #_____ Grp #_____

Policy Holder: _____

D.O.B.___ / ____ / ____ Soc. Sec. # ____ - _____ - _____

Secondary
Insurance: Name: _____

Policy #_____ Grp #_____

Policy Holder: _____

D.O.B._____ Soc. Sec. #_____

Do you have an Advance Directive? ☐ Yes ☐ No

How did you hear about us? _____

For medical & diagnostic treatment rendered to myself or dependents, I hereby authorize the following:

1. Consent to medical and diagnostic treatment by the providers of Dr. Elizabeth White's Office.
2. Payment of authorized Medicare/Healthcare insurance benefits be made on my behalf to Dr. for any services furnished to me.
3. Release of any information to obtain examination, treatment, and/or payment.
4. Photocopies of this form to be valid as the original

Signature:_____ Date: _____

PERSONAL HISTORY

Patient Name:_____ Date of Birth:_____

Date:_____ Completed By: ☐ Self ☐ Other _____

Past Medical History (please check if you had):

- ❑ High blood Pressure
- ❑ Heart Disease
- ❑ Bypass, stents or MI
- ❑ High Cholesterol
- ❑ Diabetes
- ❑ Thyroid Disorder
- ❑ Asthma
- ❑ Emphysema
- ❑ Ulcers
- ❑ Acid Reflux
- ❑ Gallstones
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Blood Clots or DVT
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Arthritis
- ❑ Sinus Allergies
- ❑ Seizures/Epilepsy
- ❑ Migraine Headache
- ❑ Depression
- ❑ Anxiety
- ❑ Colon Cancer
- ❑ Lung Cancer
- ❑ Breast Cancer
- ❑ Prostate Cancer
- ❑ Other Cancer _____

Surgeries: ☐ NONE

Procedure	Year
Appendectomy	_____
Gallbladder	_____
Hysterectomy	_____
Cardiac Bypass	_____
Cardiac Stents	_____

Other:_____

_____

_____

Immunization:

			Date:
Influenza	Yes	No	_____
Pneumonia	Yes	No	_____
Tetanus (Td or Tdap)	Yes	No	_____
Meningitis	Yes	No	_____
Shingles	Yes	No	_____
Hepatitis A	Yes	No	_____
Hepatitis B	Yes	No	_____
Gardasil (HPV)	Yes	No	_____

Social History:

Occupation:_____

Education:_____

Marital Status: _____

Children: _____

Tobacco:

- ❑ Never smoked
- ❑ Quit smoking in _____ after _____years.
- ❑ I use chewing or smokeless tobacco.
- ❑ I smoke ____ pipes/cigars a week.

Alcohol:

- ❑ NO alcohol
- ❑ I take ____ drinks/_____ ounces daily / weekly.

Do you exercise:

- ❑ NONE
- ❑ Infrequently
- ❑ _____Times/Week

Caffeine Use:

- ❑ Coffee ____Oz/Servings/Day
- ❑ Tea_____ Oz/Servings/Day
- ❑ Soda ____ Oz/Servings/Day

Medication & Strength

_____

_____

_____

_____

_____

_____

_____

_____

_____

Male Health Maintenance: **Date:**

Prostate Exam _____
Labs _____
Colonoscopy _____
Cardiac _____

Female Health Maintenance: **Date:**

Mammogram _____
Pap smear _____
Dexa Scan _____
Labs _____
Colonoscopy _____
Cardiac _____

Drug Allergies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History (mark in box that applies)

	Mother	Father	Brother	Sister	Other Relative(specify)	Age of death
High Blood Pressure						
High Cholesterol						
Coronary Artery Disease						
Congestive Heart Failure						
Peripheral Vascular Disease						
Diabetes Mellitus						
Hypothyroidism						
Hyperthyroidism						
Asthma						
Depression						
Anxiety						
Stroke						
Migraines						
Cancer						
Other _____						

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HIPPA RELEASE OF INFORMATION AUTHORIZATION FORM

I hereby authorize Dr. Elizabeth White`s Office and its affiliates, its employees and agents to release my personal health information maintained by Dr. Elizabeth White`s Office to other healthcare providers, in the event that a referral is required, for the purpose of diagnosis, treatment, claims payment, and health care services provided or to be provided to me and the information contains and identifies my name, address, social security number, member ID number and medical records.

This authorization is valid from the date of my/my representative's signature below and shall expire upon my death or written notice to revoke.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment or payment for coverage of services.

I request the following restrictions to the use and disclosure of my health information:

_____

Do we have permission to speak to any other person and/or persons regarding your healthcare and medical condition? If so, who?

_____

Name of Authorized Person Phone

Name of Patient: _____

Signature of Patient:_____

Date:_____

If applicable, Legal Representative sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative:

_____

Signature of Legal Representative:

_____

Date: _____

Name of Witness: _____

Signature of Witness: _____

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FINANCIAL POLICY

INSURANCE: If your visit is covered by your insurance plan, we will require a copy of your insurance card along with photo identification in order to allow us to verify the benefits you are eligible for and provide any copay amount that is due at the time of service. We will accept assignment of your benefits and file the insurance claim on your behalf. You will be responsible for your deductible, co-payments, or coinsurance at the time of the visit and are expected to pay any charges that your plan does not cover as a part of their benefits. Our providers are participating members of most of the larger insurance plans with members in the area.

OFFICE VISITS: We make every effort to control the cost of services to our patients. An important way that we accomplish this is by eliminating the need for mailing statements. Therefore, payment for patient responsibility is required at the time of your visit. You may pay by cash, check or credit card.

HOSPITAL VISITS: We will accept assignment of benefits for all inpatient charges and we will bill your insurance company. You will be notified of any additional balance due, if any, after your insurance company pays.

BALANCES: Any balance on your account, must be paid in full before an appointment can be scheduled. We **DO NOT** allow partial payments.

Patient/Responsible Party Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECIPIENT OF NOTICE OF PRIVACY PRACTICES

I,_____, Have reviewed and have been offered a copy of the offices notice of privacy.

_____

PLEASE PRINT NAME

_____

SIGNATURE

_____

DATE

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		DOB
ADDRESS	SSN	
CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:	**ENTITY RECEIVING THE PHI:**
	NAME: Dr. Elizabeth B White
	ADDRESS: 205 Highland Park Plaza
	CITY: Covington **STATE: LA** **ZIP: 70433**
	PHONE: (985)871-8681 **FAX: (985)871-8684**
	ATTENTION:

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

Date: Event:

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
All PHI in the record		
Progress Notes		
Laboratory Tests		
X-Ray Tests / Reports		
History and Physical Examination		
Discharge Summary		
Consultation Reports		
Itemized Billing Statement		
Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results [ ] Alcohol, drug or substance abuse treatment

[ ] Psychiatric or mental care / treatment [ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER 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 RE-DISCLOSED.
5. HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:

Personal Representative's Relationship to Patient: