

Acadiana Center for Orthopedic and Occupational Medicine, LLC

204 Energy Parkway Suite B
Lafayette, LA 70508
Phone (337) 269-0136 Fax (337) 233-8525

PATIENT INFORMATION

PRINT

Patient's Name: _____ Cell #: _____
(Last) (First) (Mi)

Patient's Address: _____ Phone #: _____
Street City State Zip

Social Security #: _____ / _____ / _____ Age: _____ Date of Birth: _____ / _____ / _____

Sex: M / F Martial Status: S M W D

Patient's Employer: _____ Work Phone: _____
(If Minor, list Parent's Employer)

Alternate Contact Person: _____ Phone #: _____

Referred By: _____

Have you seen any of our physicians before or had any services at this clinic? _____ If yes, when and for what injury? _____

Reason for your visit today? _____
(Injury or Illness)

*******OFFICE USE ONLY*******

INSURANCE INFORMATION

VERIFICATION

Insurance Name _____

Effective Date _____

Insurance Phone # _____

Copay _____

Primary Card Holder _____

Coinsurance _____

Primary DOB: ____ - ____ - ____ SS# ____ - ____ - ____

ID / Policy # _____

Group # _____

Reason for visit? _____

Date Symptoms Began: _____

Responsible Party _____

Phone _____

Address: _____ City _____ State _____ Zip _____

Please read and sign the back of this form

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AUTHORIZATION FOR EVALUATION/TREATMENT AND RELEASE OF MEDICAL FORMS

I hereby authorize the physicians of Acadiana Center for Orthopedic and Occupational Medicine to examine and evaluate the patient on the reverse side. I authorize the release of my medical records to any doctor, employer/employer representative, potential employer, insurance company(s), Voc. Rehab, Rehab nurse(s) all information they may request associated with my medical care. I also request that you release my medical records to the physicians of Acadiana Center for Orthopedic and Occupational Medicine.

The opinions rendered in this case are the opinions of the physicians of Acadiana Center for Orthopedic and Occupational Medicine. This evaluation is being conducted on the basis of the medial examination and the documentation provided, with the assumption that the material is true and correct. If more information becomes available at a later date, an additional service/report/reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment, examination, and documentation. This opinion does not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.

Print Full Name _____

Signature _____ **Date** _____ **ID Checked by** _____
(Staff Initials & Date)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and will list any restriction(s) concerning my personal medical information: _____

List any restriction(s) here

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____

Date: _____