THIBODAUX SURGICAL SPECIALISTS

Thibodaux Surgical Specialists
PATIENT INFORMATION

PLEASE PRINT

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 IF "YES", ____ 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

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 _____