MRN #:_____ **Daniel Clinic Patient Registration** EMP. _____

(Please PRINT)

Patient Information			
Last Name:	First Name:	M.I.:	Preferred Name:
Mailing Address:		Apt #:	
Physical Address:			
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Primary Care Provider or Pediatrician:	Date of Birth:	Sex: ☐ Male ☐ Female	
Marital Status:	Social Security Number:	US Military/Veteran: ☐ No ☐ Yes	
Employer Name:	Employer Contact Name:		
Emergency Contact:	Phone #:	Relationship to Patient:	

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone #:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**		
Email Address:	Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No	
Race (select one): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Ethnicity (please select one): ☐ Hispanic of Latino ☐ Not Hispanic of Latino ☐ Decline	Religion (please select one): ☐ Catholic ☐ Pentecostal ☐ Baptist ☐ Other ☐ Methodist
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi& Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other		
Preferred Pharmacy Name & Location:		

Primary Insurance	**Secondary Insurance**
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security Number:	Policy Holder's Social Security Number:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Daniel Clinic's Payment Policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I herebyassign to Daniel Clinic all money to which I am entitled for medical expenses related to the services performed from time to time by Daniel Clinic, but not the exceed my indebtedness to Daniel Clinic. I authorize Daniel Clinic to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Daniel Clinic by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

I have reviewed/received a copy of Daniel Clinic's Privacy Policy Notice. ☐ **(Initials)**

Signature of Responsible Party: **x**_____ **Date:** _____

Printed Name of Responsible Party: **x**_____ **Date:** _____

MRN_____

DANIEL CLINIC

APPOINTMENT NO SHOW POLICY

EFFECTIVE 08/01/2021

We are experiencing an increasing number of no-show appointments. We would appreciate a simple call to our office 24 hours in advance to let us know that you are unable to make your appointment. Our patients are very important to us and we strive to meet their needs. If you do not show up for your appointment **OR** if you call us to cancel with less than 24 hours notice, there will be a $25 charge applied to your account that must be paid before next scheduled appointment. Thank you for helping us keep our schedule as open as possible for patients that are in need.

By signing below, I acknowledge that I have been informed of Daniel Clinic's No-Show Policy.

_____

Patient Name (Print)

_____ _____

Patient or Guardian Signature Date

Health History

Patient Name_____ **Birthdate** _____/_____/_____

To help us meet all your healthcare needs, please fill out **both pages** of this form completely. This is a confidential record of your medical history and will be kept in this office

Today's date_____
Place of birth_____
Highest level of education_____
Occupation_____
Previous occupations_____
Marital Status_____
Hobbies_____
Exercise/recreation_____
Habits:
Smoking (type & amount per day)_____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last dental exam_____
Please list all allergies (foods, drugs, environment)
_____
_____
_____
Have you ever taken Fen-Phen/Redux? _____

When was your last physical exam? _____
Name of doctor_____ Phone # _____
Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ None
_____
_____
_____
_____

Please list all medications you are currently taking (include nonprescription drugs): ☐ None
_____
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): ☐ None
_____
_____
_____

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____
_____

Past Medical History

Have you ever had the following: (Check "Yes" or "No" , leave blank if uncertain)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Measles	☐	☐	Epilepsy	☐	☐	Hives or Eczema	☐	☐
Mumps	☐	☐	Migraine headaches	☐	☐	AIDS or HIV+	☐	☐
Chickenpox	☐	☐	Tuberculosis	☐	☐	Infectious Mono	☐	☐
Whooping cough	☐	☐	Diabetes	☐	☐	Bronchitis	☐	☐
Scarlet Fever	☐	☐	Cancer	☐	☐	Mitral Valve Prolapse	☐	☐
Diphtheria	☐	☐	Polio	☐	☐	Stroke	☐	☐
Smallpox	☐	☐	Glaucoma	☐	☐	Hepatitis	☐	☐
Pneumonia	☐	☐	Hernia	☐	☐	Ulcer	☐	☐
Rheumatic Fever	☐	☐	Blood or Plasma transfusion	☐	☐	Kidney Disease	☐	☐
Heart Disease	☐	☐	Back trouble	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	High or low blood pressure	☐	☐	Bleeding Tendency	☐	☐
Venereal Disease	☐	☐	Hemorrhoids	☐	☐	Any other disease	☐	☐
Anemia	☐	☐	Asthma	☐	☐	(Please list)_____		
Bladder Infection	☐	☐	Date of last chest x-ray_____			_____		

Family History

Has any blood relatives had any of the following: (Check "Yes" or "No", leave blank if uncertain)

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Cancer	☐	☐	_____	Stroke	☐	☐	_____
Tuberculosis	☐	☐	_____	Epilepsy	☐	☐	_____
Diabetes	☐	☐	_____	Allergies	☐	☐	_____
Heart Disease	☐	☐	_____	Anemia	☐	☐	_____
High Blood Pressure	☐	☐	_____	Bleeding Tendency	☐	☐	_____

Family History (continued)
(Check "Yes" or "No", leave blank if uncertain)

Condition	Yes	No	Relationship
Asthma	☐	☐	
Chronic lung disease	☐	☐	
Drug or Alcohol problem	☐	☐	
Mental illness	☐	☐	
Leukemia	☐	☐	
Migraine Headaches	☐	☐	
Obesity	☐	☐	
Thyroid Disease	☐	☐	
Ulcer	☐	☐	
Depression	☐	☐	
High Cholesterol	☐	☐	
Kidney Disease	☐	☐	
Glaucoma	☐	☐	
Gout	☐	☐	

Present age (health-good,fair,poor)/Age of death (cause of death)

Father_____
Mother_____
Siblings_____
_____
_____
_____
_____
Spouse_____
Children_____
_____
_____
_____
_____
_____

Do you have now or have you had with the pas year: (Check "Yes" or "No", leave blank if uncertain)

Condition	Yes	No
Weakness or paralysis	☐	☐
Tire easily or weakness	☐	☐
Recent weight changes	☐	☐
Change in appetite	☐	☐
Sensitivity to cold or heat	☐	☐
Persistent fever	☐	☐
Night sweats or hot flashes	☐	☐
Skin rash	☐	☐
Skin trouble or changes	☐	☐
Change in nails or hair	☐	☐
Headaches	☐	☐
Easy bleeding or bruising	☐	☐
Double vision	☐	☐
Blurred vision	☐	☐
Eye pain	☐	☐
Infected eyes	☐	☐
Do you wear glasses/contacts	☐	☐
When was you last eye exam _____		
Ringing in the ears	☐	☐
Discharge from the ears	☐	☐
Ear pain	☐	☐
Decrease in hearing	☐	☐
Frequent nosebleeds	☐	☐
Frequent colds	☐	☐
Sinus trouble	☐	☐
Loss of smell	☐	☐
Persistent hoarseness	☐	☐
Sore throat	☐	☐
Sore tongue or gums	☐	☐
Lump or discharge for breast	☐	☐
A persistent cough/throat clearing not associated with known illness (lasting more than 3weeks)	☐	☐

Condition	Yes	No
Shortness of breath	☐	☐
Bloody sputum	☐	☐
Wheezing	☐	☐
Chest pain or discomfort	☐	☐
Purple fingers or lips	☐	☐
Swelling of hands, feet, ankles	☐	☐
Difficulty in breathing	☐	☐
Palpitations or fluttering of the heart	☐	☐
Leg cramps on walking or at night	☐	☐
Enlarge veins	☐	☐
Difficulty swallowing	☐	☐
Heartburn	☐	☐
Frequent belching	☐	☐
Abdominal cramping	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomited or coughed up blood	☐	☐
Chronic diarrhea	☐	☐
Chronic constipation	☐	☐
Rectal bleeding	☐	☐
Black tarry stools	☐	☐
Dark urine	☐	☐
Yellow jaundice	☐	☐
Frequent urination (day)	☐	☐
Frequent urination (night)	☐	☐
Increase in thirst	☐	☐
Painful urination	☐	☐
Leakage of urine	☐	☐
Difficulty in stating urine	☐	☐
Blood in urine	☐	☐
Lack of sex drive	☐	☐
Hemorrhoids	☐	☐
Backaches	☐	☐

Condition	Yes	No
Joint pain or stiffness	☐	☐
Swollen joints	☐	☐
Muscle cramps or spasms	☐	☐
Sleeplessness	☐	☐
Seizures	☐	☐
Depression	☐	☐
Memory loss	☐	☐
Poor coordination	☐	☐
Dizziness or fainting spells	☐	☐
A living will/advance directive	☐	☐
Men only:		
Discharge from penis	☐	☐
Pain or lump in testicles	☐	☐
Impotence	☐	☐
Women only:		
Age period began _____		
How many days do periods last_____		
How many days between periods_____		
Is the flow heavy?	☐	☐
Do you bleed or spot between periods?	☐	☐
Do you have pain or cramps?	☐	☐
Date of last period? _____		
Date of last pelvic exam? _____		
Date of last mammogram? _____		
Any itching in vaginal area?	☐	☐
Pain with intercourse?	☐	☐
Type of birth control? _____		
Number of pregnancies _____		
Number of full term births _____		
Number of preterm births _____		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X_____ _____

Signature of Patient or Parent if Minor — Date

_____

Physician's Signature

DANIEL CLINIC
5326 Oak Street / P.O. Box 487
Saint Francisville, LA 70775
Ph (225) 635-5848 Fax (225) 635-5847

Patient Name: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT

I consent to and authorize Daniel Clinic personnel to perform care and treatment including but not limited to medical treatment, laboratory, and/or diagnostic testing that may be ordered by said personnel.

I certify that I have read and understand the above authorization for medical treatment.

X_____
Signature of Patient (or Guardian)

ADVANCE DIRECTIVES

I have a Living Will ☐ Yes ☐ No
I have a Medical Power of Attorney ☐ Yes ☐ No

If Yes, I understand it is my responsibility to provide a copy for my medical records.

X_____
Signature of Patient (or Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of Daniel Clinic's Privacy Notice.

I understand that a privacy officer has been appointed and that any questions regarding that Privacy Act may be directed to the HIPAA Privacy Officer.

I have read and understand the facility's Privacy Notice. I understand that I have the right to restrict how my protected health information may be used. I also understand that the facility may refuse admission should the restrictions I place on my protected health information interfere 1) with the clinic's ability to treat and/or bill me for services rendered or 2) with the operations of the facility.

X_____
Signature of Patient (or Guardian)

Daniel Clinic –PHI Authorization Today's Date: ____/____/_____

Patient Name: _____ DOB: ____/____/_____

Daniel Clinic may not use or disclose your protected health information to others without your authorization. In order for someone else to receive your protected health information please complete this form in its entirety.

I hereby authorize Daniel Clinic and any of its employees to use or disclose my patient health information to the following person(s), entity(s), or business associates of this office:

_____ _____

_____ _____

_____ _____

_____ _____

Patient health information authorized to be disclosed:
□ Medical Care □ Legal □ Insurance □ Personal □ All Information Other: _____

This authorization will expire on ____/____/_____.

I understand that I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure preceding this authorization.
2. Knowledge of any fees involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the patient health information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment in any way.

_____ ____/____/_____
Signature of Patient or Patient's Authorized Representative Date

_____ ____/____/_____
Daniel Clinic Employee Signature Date

Authorization for Release of Protected Health Information
(Records over 25 pages should be mailed)

Patient Name: _____ DOB: ____/____/_____

Guardian's Name: _____ DOB: ____/____/_____
If patient is under 18 years of age

Release Information from:

Doctor/Clinic's Name: _____ **Phone Number:** _____

Address: _____ Fax Number: _____

Release to: Daniel Clinic

Purpose of Disclosure: □ Medical Care □ Legal □ Insurance □ Personal □ Other: _____

Description of Information to be Used or Disclosed: □ Complete Information □ Visit Notes □ Labs/Radiology □ Verbalized

□ Other/Explain: _____

I understand that:

1) I may refuse to sign this authorization and that it is strictly voluntary.
2) If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3) I acknowledge, and hereby consent to such, that the released information may contain genetic test results, alcohol/drug abuse, psychiatric, HIV testing, HIV results or AIDS information.
4) I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
5) 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.
6) I understand that I may see and obtain a copy of the information described on this form if I ask for it.
7) I may get a copy of this form after I sign it.

Signature of Patient/Guardian: _____ **Date:** ____/____/_____

Relationship to Patient: □ Self □ Mother □ Father □ Child □ Other: _____

This authorization will expire on: ____/____/_____. If I fail to specify an expiration date, this authorization will expire six months from the date on which it was signed.

Witness Signature: _____ Date: ____/____/_____
For Employee

Daniel Clinic
5326 Oak St/PO Box 487
St. Francisville, LA 70775
Phone: 225-635-5848
Fax: 225-635-5847