Elizabeth B White, M.D.
205 Highland Park Plaza
Covington, LA 70433

TODAY's DATE:_____

LAST NAME:_____FIRST:_____MIDDLE:_____

PATIENT ADDRESS:_____

CITY:_____STATE:_____ZIP CODE:_____

HOME PHONE: (____) _____WORK PHONE:(____) _____

CELL PHONE:_____

SEX: M_____ F _____ SINGLE____DIVORCED___MARRIED___WIDOWED____

DATE OF BIRTH: _____ AGE_____ SSN_____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

_____

OCCUPATION: _____

SPOUSE / PARENT INFORMATION

NAME: _____DATE OF BIRTH: _____

EMPLOYER NAME: _____ WORK PHONE: _____

SSN OF SPOUSE / PARENT: _____

RELATIVE / FRIEND / OTHER THAN SPOUSE / PARENT WE CAN CONTACT IN THE EVENT OF AN EMERGENCY

NAME: _____DATE OF BIRTH: _____

RELATIONSHIP: _____

ADDRESS: _____

STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____

CELLL PHONE: _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE CO: _____

NAME OF INSURED: _____

RELATIONSHIP TO INSURED: _____ SELF _____ SPOUSE _____ CHILD _____ OTHER

NAME OF SECONDARY INSURANCE CO: _____

RELATIONSHIP TO INSURED: _____ SELF _____ SPOUSE _____ CHILD _____ OTHER

ELIZABETH B WHITE M D INC

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

NAME: _____

BIRTHDATE: _____ **SOCIAL SECURITY #:** _____

I understand that as part of my healthcare, this organization originates and maintains a health record describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan for future care or treatment.

I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing care quality and reviewing the competency of healthcare professionals

I UNDERSTAND THAT I HAVE THE RIGHT:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment to healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action.

_____ I request the following restrictions to the use or disclosure of my health information;

_____

_____

PATIENT:

Signature of Patient or Legal Representative: _____

Date: _____ Witness: _____

Office Use Only:

_____ Accepted _____ Denied

Signature: _____ Title: _____

Date: _____