ACCESS 2day HEALTH

Today's Date:_____

Patient Information:

Patient's Legal First Name: _____ Middle Initial: ____ Last Name: _____

DOB: _____ SSN: _____Phone: _____

(SSN is required for Access 2 Day Benefits)

Access 2Day Health Employer: _____
(Policy Holder's Employer: Self, Spouse, Parent, etc..)
Pharmacy: _____

Primary Care Physician: _____

What are you being seen for today? (PLEASE LIST ALL SYMPTOMS)

_____

_____

_____

_____

_____

Onset date & time: _____
(When did it start? How many days?)

RESPIRATORY SCREEN

Do you have a fever?	YES	NO
Do you have a cough and/or difficulty breathing?	YES	NO
Have you been in close contact with a family member or friend that is known to be positive for COVID-19?	YES	NO

Thank you for your cooperation.

Patient Information:

Patient Legal First Name: _____ M: ___ Last Name: _____

DOB: _____ Sex: Male/Female SSN: _____-____-_____ Email: _____

Home Address: _____ City: _____ State: ___ Zip:_____

Mailing Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Cell: _____ Work: _____ Ext: ____

Primary Care Provider: _____ Phone:_____

Marital Status: ___ M ___ S ___ D ___ W ___ Other Language:_____ Race: _____

Ethnicity: Hispanic / Non Hispanic / Decline to Specify

Access 2Day Health Employee Information:

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: ____ Zip:_____

If Access Health is through a spouse or parent, who is their employer? _____

Responsible Person's or Spouse Information:

Legal First Name: _____ M: ___ Last Name: _____

Relationship to Patient: _____ DOB: _____ SSN : _____-____-_____

Address: _____ City: _____ State: ___ Zip: _____

Home #: _____ Cell:_____ Work:_____

Emergency Contact:

Emergency Contact: _____ Relationship_____ Phone:_____

Preferred Pharmacy:

Name:_____ Street:_____ City:_____Phone:_____

Authorized Contacts:

Please list all persons who can inquire/discuss/relay information pertaining to your personal health information.

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

Cenla Family Medicine Associates, LLC
Central Louisiana Foot and Ankle Specialists
Alexandria Gastroenterology Associates

Patient's Notification and Signature Form

Print Patient Name: _____ Date of Birth: _____

Please initial all:

I have received a copy and have read the HIPPA Notice of Privacy Practices Policy for the clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Patient Consent for Use and Disclosure of Protected Health Information Policy for th e clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Payment Policy for the clinic. _____ Patient or Guardian's Initial

I have received a copy and have read the No Show Policy for the clinic.
_____ Patient or Guardian's Initial

I have received a copy and have read the Authorization of Care for the clinic.
_____ Patient or Guardian's Initial

I authorize the release of any information necessary to process this claim and authorize payment of benefits to Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla, and/or Alexandria Gastroenterology Associates for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.
_____ Patient or Guardian's Initial

I authorize my insurance company to pay benefits directly to Cenla Family Medicine Associates, LLC and/or Cardiac and Vascular Services of Cenla for charges relating to all services.
_____ Patient or Guardian's Initial

PRESCRIPTION HISTORY CONSENT
I agree that the clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Yes_____ (please initial) No _____ (please initial)

I recognize my responsibility and my rights as a patient of Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists and/or Cardiac and Vascular Services of Cenla.

_____ _____
Patient or Guardian's Signature Date

New Patient History Questionnaire:

Name: _____DOB: _____ Occupation: _____

Gender: Male Female

Marital Status: Single Married Widowed Separated Divorced

Use of: Alcohol_____ Tobacco_____ Recreational Drugs_____

Family History

Relation	**Age**	**Living**	**Deceased**
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Sibling History

Number of brothers living _____ Number of brothers deceased_____

Number of sisters living _____ Number of sisters deceased _____

Prescription Medication (that you are currently taking)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

OTC Medications (that you are currently taking – please include any herbs or supplements)

_____ _____ _____

_____ _____ _____

Medication Allergies

_____ _____ _____

_____ _____ _____

Surgeries

_____ _____ _____