DEMOGRAPHICS INTAKE FORM

Thibodaux Regional Physician Network

Acct #: _____ Completed Date: _____

Rendering Prov (PHY): _____ LOC: ☐ CV ☐ EN ☐ FAM ☐ IM ☐ NL ☐ NS ☐ OR ☐ PM ☐ PU ☐ RA

Financial Class (F/C): _____ P-INS Code: _____ S-INS Code: _____

Attached: ❑ Request for Confidential Communications

PATIENT INFORMATION

Prefix: Mr./Mrs./Other: _____ Patient*⇳: _____ (Last) _____ (First) _____ (Middle)

Suffix: Jr./Sr./Other: _____ Previous Name: _____

Mailing Address⇳: _____ (If PO Box, complete Street Address Below) _____ (City) _____ (State) _____ (Zip)

Street Address: _____ _____ (City) _____ (State) _____ (Zip)

Home #⇳: _____ Cell #: _____ Work #: _____ Ext: _____

Date of Birth*⇳: _____ Sex*⇳: ☐ Male ☐ Female ☐ Unknown ☐ Decline to specify ☐ Other: _____

Marital Status*⇳: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Social Security#⇳: _____ Employer: _____

Employment Status⇳: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Military Active ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Patient & Responsible Party are the same*⇳? ☐ Yes ☐ No (complete 2nd page)

Emergency Contact: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Primary Insurance⇳: _____ Secondary Insurance: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

☐ Provide copy of insurance card(s) to be scanned⇳ Email: _____

Race*⇳: ☐ African American ☐ Caucasian/White ☐ Unknown ☐ Decline to specify ☐ Other: _____

Ethnicity*⇳: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Decline to specify

Leave message at what phone number? ☐ Home ☐Work ☐ Cell ☐ None

Preferred Language*⇳: ☐ English ☐ Spanish ☐ Unknown ☐ Decline to specify ☐ Other: _____

How were you referred to our practice: ☐ Physician ☐ Friend/Relative _____
☐ Newspaper ☐ Radio ☐ Healthsource ☐ Other: _____

Do you have an advanced directive (living will, durable power of attorney)? ☐ Yes ☐ No → If 'Yes', provide copy:

Rec'd by: _____ Date: _____

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', office staff to assist in completing a Hospice/HHA/NH/SNF Facility Information Form and an ABN Form

❑ Hospice/HHA/NH/SNF Facility Info Form
❑ ABN Form