DEMOGRAPHICS INTAKE FORM

Thibodaux Regional Physician Network

LOC: CV EN FAM IM NL NS OR PM PU RA TWC

Acct #: ____________ ☐ Request for Confidential Communications Attached Completed Date: ____________

P-INS Code: ____________ S-INS Code: ____________

PATIENT INFORMATION

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

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

Mailing Address 1*: ____________ (If PO Box, complete Street Address Below) ____________ (City) ______ (State) ______ (Zip)

Street Address 2: ____________ ____________ (City) ______ (State) ______ (Zip)

Home #: ____________ Cell #: ____________ Work #: ____________ Ext: ______

Circle the preferred phone #/email contact. Leave message at what phone number? ☐ Home ☐ Work ☐ Cell ☐ None

Email*: ____________ Gender*: ☐ Male ☐ Female Other: ______

Date of Birth*: ____________ Marital Status*: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Social Security#: ____________

Employer: ____________ Occupation: ____________

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ______ (MMDDYY) ☐ Military Active ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A Patient & Responsible Party are the same*? ☐ Yes ☐ No (complete below)

Race*: ☐ African American ☐ Caucasian/White ☐ Other: ______

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language*: ☐ English ☐ Spanish ☐ Other: ______

☐ Provide copy of insurance card(s) to be scanned ⇳ (if not, complete below) Do you have wellcare/preventative coverage for annual exams: ☐ Yes ☐ No

Primary Insurance: ____________ Secondary Insurance: ____________

Primary Ins Policy #: ____________ Secondary Ins Policy #: ____________

Group #: ____________ Group #: ____________

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

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT (NOT SELF), THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Prefix: Mr./Mrs./Other: ______ Responsible Party: ____________ (Last) ____________ (First) ____________ (Middle)
(Employer Info if work related)

Suffix: Jr./Sr./Other: ______ Relationship to Patient: ____________ Social Security #: ____________

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 Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Email: ____________ Preferred Language: ☐ English ☐ Spanish ☐ Other: ______

Employer: ____________

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