Patient Registration

Name (First, Middle, Last):_____ Preferred Name: _____

Social Security # : _____-_____-_____ **Sex:** M / F **Patient DOB:** _____-_____-_____

Address : _____ Lot / Apt # : _____

City : _____ **State :** _____ **Zip Code :** _____ Marital Status: _____

Cell Phone # : (_____) _____-_____ **Home Phone # :** (_____) _____-_____

Race : American Indian Alaskan Indian Asian Black Native Hawaiian White Other : _____

Ethnicity : Hispanic or Latino NOT Hispanic or Latino Decline to Specify

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Emergency Contact *(Required for ALL patients)*

Name : _____ Relation : _____

Phone # : (_____) _____-_____

Responsible Party *(if under age of 18)*

Name : _____ Relation : _____

Phone # : (_____) _____-_____

Insurance Information *(If patient is NOT the policy holder)*

Primary Policy Holder : _____ **Relation :** _____

DOB : _____-_____-_____ **Social Security # :** _____-_____-_____

Secondary Policy Holder : _____ **Relation :** _____

DOB : _____-_____-_____ **Social Security # :** _____-_____-_____

Release Authorization

If CSC has permission to release this patient's protected health information to this person, check off AUTH PHI.
If CSC has permission to allow this person to check in the patient (only if under 18), check off APPROVED FOR CHECK-IN.

Name : _____ Relation : _____ ☐ AUTH PHI ☐ APPROVED FOR CHECK-IN

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Name : _____ Relation : _____ ☐ AUTH PHI ☐ APPROVED FOR CHECK-IN

☐ ***I DO NOT WISH TO HAVE ANY OF MY PROTECTED HEALTH INFORMATION RELEASED TO ANYONE***

By signing below, I certify that Central Stat Care has provided me with a copy of the HIPAA Agreement, Notice of Privacy Practices, and Financial Policy. I have reviewed, understand, and accept the policies listed therein.

Patient/Responsible Party Signature : _____ Date : _____

Central STAT Care

Medical History Questionnaire

11055 Shoe Creek Dr.
Central, LA 70818
225-261-4493

Name: _____ DOB: _____

Physicians

Primary Care Physician _____

Do you see any medical specialist? ☐ Yes ☐ No If yes, please list.

1. _____ 2. _____ 3. _____

Medications

Current Medications

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Please list all drug allergies: ☐ No known drug allergies

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Past Medical History

Have you ever had or do you have now any of the following (please check all that apply)

☐ High Blood Pressure	☐ Emphysema	☐ Erectile Dysfunction	☐ ADD/ADHD
☐ High Cholesterol	☐ Sarcoidosis	☐ Arthritis	☐ Migraines
☐ High Triglycerides	☐ Sleep Apnea	☐ Lupus	☐ Seizures
☐ Heart Attack	☐ Crohn's Disease	☐ Lower Back Pain	☐ Strokes
☐ Congestive Heart Failure	☐ Colitis	☐ Diabetes	☐ Chronic Pain
☐ Irregular Heart Beat	☐ Stomach Ulcers	☐ Thyroid Disease	☐ Obesity
☐ Blood clots	☐ Heart Burn	☐ Depression	☐ Anemia
☐ Asthma	☐ Hepatitis	☐ Anxiety /Insomnia	☐ Cancer_____

Other: _____

Past Surgical History

Have you had any surgical procedures? Please list the procedure and year.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Lifestyle & Social History

Do you smoke? Yes No Former How much? Packs/Cigars per day: _____ #of years smoking: _____

Do you drink alcohol? Yes No How much? _____

Do you use recreational drugs? Yes No List: _____

Occupation: _____

Family History

Check if there is any history in your family of: (please check all that apply)

☐ High Blood Pressure	☐ Blood Disorder	☐ Asthma/COPD
☐ Diabetes	☐ Epilepsy	☐ High Cholesterol
☐ Stroke	☐ Obesity	☐ Colon Cancer
☐ Heart disease	☐ Kidney Disease	☐ Breast Cancer

Other: _____