Serving patients in and around:
SHREVEPORT, MINDEN, NATCHITOCHES, WINNSBORO

(318) 239-4860
www.drmdclinics.com

2021 NEW PATIENT REGISTRATION FORM

Name: ____________________ ____________________ ____________________
Last First Middle

Date of Birth: _____/_______/_______ Social Security Number: ____________________

Male ☐ Female ☐ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address: ____

City, State: ____ Zip Code: ______________

Home Phone: ________________ Work Phone: ________________ Cell: ____________________

Email: ____

Employer: ___________________________ Occupation: ________________________

Employer Address: ____

Ethnicity: ______________________________ ☐ Decline not to answer

EMERGENCY CONTACT

IF PATIENT IS UNDER 18 YEARS OF AGE, PERSON RESPONSIBLE FOR PAYMENT MUST BE PRESENT

Emergency Contact: (someone that does not live with you) ___________________________________

Emergency Contact Phone: ____________________ **Relationship**: ________________________

Name: _______________________ _______________________ _____________________
Last First Middle

Date of Birth: ____________________ Social Security Number: _______________________

Address: ____

City, State: ____ Zip Code: ______________

Home Phone: _________________ Work Phone: ________________ Cell Phone: _____________

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PRIMARY PHYSICIAN & PHARMACY INFORMATION

Primary Physician: ______________________________ Phone: ____________________________________

Referring Physician: ______________________________ Phone: ____________________________________

Pharmacy: ______________________________________ Phone: ___________________________________

PRIMARY INSURANCE INFORMATION

PRIMARY Ins Co Name: ________________________________ **Policy #:** ___________________________

Subscriber #: ___________________________ Relationship: ___________________________

Date of Birth: ___________________________ Social Security #: ___________________________

SECONDARY INSURANCE INFORMATON

SECONDARY Ins Co Name: ______________________________ **Policy #:** ___________________________

Subscriber #: ___________________________ Relationship: ___________________________

Date of Birth: ___________________________ Social Security #: ___________________________

IF MEDICARE IS SECONDARY INSURANCE, PLEASE EXPLAIN WHY: ___________________________

IMPORTANT: Please Acknowledge AND Initial:

I understand that if I have a commercial insurance as my primary insurance, I am not able to use Medicaid as my secondary.

Initial ___________

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ASSIGNMENT OF BENEFITS

I authorize MD Clinics to file all necessary documents for insurance purposes and to release any and all copies of medical records requested to my insurance company(ies) for the purpose of determining benefits. I authorize payment of medical benefits under any insurance policy(ies) to MD Clinics for any medical services rendered.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_________________________________ _________________________________

Patient / Responsible Party Signature Date

DISCLOSURE TO FAMILIES, LOVED ONES AND CARE SUPPORT NETWORK

I authorize MD Clinics, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize MD Clinics to disclose my personal health information to the following people:

Name: __________________________ Relationship: _____________ Phone: ________________

Appt Info ☐ Clinical Information* ☐ Billing Information ☐

Name: __________________________ Relationship: _____________ Phone: ________________

Appt Info ☐ Clinical Information* ☐ Billing Information ☐

Name: __________________________ Relationship: _____________ Phone: ________________

Appt Info ☐ Clinical Information* ☐ Billing Information ☐

ADVANCED DIRECTIVES:

Do you have one or more of the following:

Living Will	**Durable Power of Attorney**	**Do Not Resuscitate (DNR)**
☐ **Yes**	☐ **Yes**	☐ **Yes**
☐ **No**	☐ **No**	☐ **No**

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ELECTRONIC COMMUNICATIONS

Electronic communication can include one of the following: patient treatment plans, physician notes, patient lab results, scheduling, or other personal health information related to your care plan at MD Clinics. We offer the following convenient methods to communicate and get access to your health information:

Care Space Patient Portal

By checking the below box and signing below, you agree to have access to your medical records electronically through the ***Care Space*** patient portal

☐ Yes! Enroll me in Care Space so I can get quick access to my charts.

Email & Text

By checking the below boxes and signing below, you agree to receive communications from MD Clinics. Below is where you can send me information, appointment reminders, or general queries regarding my care at MD Clinics. I opt-in to receive communications via the following methods:

☐ Yes! Please send me emails at the following email address:

____

☐ Yes! Please text* with me at this number:

____

**Text messaging rates are based on individual carriers.*

By signing below, I understand that I am responsible for protecting my online/electronic access and personal information.

_______________________________________ ____________________

Patient / Responsible Party Signature Date