SANSON FAMILY MEDICINE
NEW PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY

Patient's Name: ______________________________ DOB: ____ / ____ / ____ Sex: M / F

Race: __________ Language ________________ Do you have a living will? ____Yes ____No

Mailing Address: ______________________________ Cell Number: (____) ______ - ________

Home address if different than mailing ____

City / State / Zip: ______________________________ Home Number: (____) ______ - ________

Drivers License Number: ________________________ Social Security: ______ - ______ - ________
(For Insurance purposes only)

Email Address: ____________________________________

Preferred Pharmacy: ____________________________ Address: ________________________

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Employer: ____________________________________ Work Number: (____) ______ - ________

Spouse's Name / Parents Name (if patient is a minor) ____________________________________

Spouse / Parent Social Security Number: ______ - ______ - ________ DOB: ____ / ____ / ____

Spouse / Parent Employer: ________________________ Work Number: (____) ______ - ________

In Case of Emergency Contact: ______________________ Phone Number: (____) _____ - ________

Relationship to Patient: ________________________

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Who Can We Release Your Medical Records To:
Name: ____________________ Relationship: ______________ Number: (____) _____ - ________

CONSENT TO TREATMENT: I hereby voluntarily give permission to all providers at Sanson Family Medicine for the necessary medical treatment for the above named patient.

________________________________ ________________________
Signature of Patient or Legal Guardian **Date**

Insurance Information:

Primary Insurance: ______________________________ ID Number: ____________________
Card Holder Name: ______________________________ **D.O.B.** ____________________
Secondary Insurance: ______________________________ ID Number: ____________________
Card Holder Name: ______________________________ **D.O.B.** ____________________

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PLEASE BE SURE TO GIVE THE RECEPTIONIST YOUR INSURANCE CARD AND DRIVER'S LICENSE SO THAT WE MAY MAINTAIN A COPY IN YOUR CHART. Explanation of Practice Policy: Patients who carry any form of medical or surgical insurance should know that all services furnished are charged directly to the patient and that he or she is responsible for payment. We will help you prepare your primary forms to assist in the making of collections from your insurance company. However, WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT YOUR CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY. This is a contract between you and / or your employer and the insurance company. YOUR BILL WITH US IS YOUR RESPONSIBILITY. All insurance forms processed by this office and any proceeds there form, prior to payment in full, are assigned to this practice and I authorize payment of medical and surgical benefits directly to Sanson's Family Medicine, Inc., and / or Marshall V. Sanson MD. I authorize the use and disclosure of individually identifiable health information relating to me, which is called "Protected Health Information" under the federal health privacy law. I authorize the release of any medical records or other health information necessary to process claims on my behalf or as necessary to facilitate my care. I agree to be fully responsible for all lawful debts incurred by myself or my minor child for services received from Sanson's Family Medicine, Inc., whether those services are covered by insurance or not.

________________________________ ____ / ____ / ____
Patient of responsible Party Signature Date

HISTORY AND PHYSICAL

Patient Name: ________________________________ DOB: _____ / _____ / _____ Age: ________
Address: ________________________________ Cell Number: (____) _______ - ________
City / State / Zip: ________________________________ Home Number: (____) _______ - ________

Allergies: (List any Food or Drug Allergies) ____
____

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Past Medical History: Please check all or any conditions you have had in the past.

____ AIDS
____ Alcoholism
____Anemia
____ Anorexia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bleeding Disorder
____ Breast Mass
____ Bronchitis
____ Cancer __________
____ Cataract
____ Chicken Pox
____ Diabetes
____ Emphysema
____ Epilepsy
____ Glaucoma
____ Goiter
____ Gout
____ Heart Disease
____ Hepatitis
____ Hernia
____ Herpes
____ High Cholesterol
____ HIV Positive
____ Hypertension
____ Kidney Disease
____ Liver Disease
____ Measles
____ Migraines
____ Miscarriage
____ Mononucleosis
____ Multiple Sclerosis
____ Mumps
____ Pacemaker
____ Pneumonia
____ Polio
____ Prostate Problems
____ Psychiatric Problems
____ Rheumatic Fever
____ Scarlet Fever
____ Stroke
____ Suicide Attempt
____ Thyroid Problems
____ Tonsillitis
____ Tuberculous
____ Ulcer Stomach
____ Ulcer Skin
____ Venereal Disease
____ Other____________________
____

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Past Surgical History: List all operation(s) you have had in the past years, and what year they were done

1) ____ Year: __________
2) ____ Year: __________
3) ____ Year: __________
4) ____ Year: __________
5) ____ Year: __________

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ADULT PATIENTS ONLY TO FILL THIS SECTION OUT

Do you smoke? _____ Yes _____ No If yes, how many packs a day? __________
Do you drink? _____ Yes _____ No If yes, how often? ____________________

Number of Pregnancies __________ Number of Live Births __________
Number of Abortions ____________ Number of Miscarriages _________

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Past Family History: Check all that apply to any of your blood relatives

____ Arthiritis
____ Kidney Disease
____ Stroke
____ Tuberculous
____ High Blood Pressure
____ Heart Disease
____ Cancer __________
____ Diabetes
____ Other ____________________

SANSON FAMILY MEDICINE
HIPPA AUTHORIZATION TO RELEASE or OBTAIN HEALTH INFORMATION

(Including paper, oral, and electronic information)

By signing this form, I authorize you to release or obtain confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the facility listed below.

SANSON FAMILY MEDICINE
2309 ARKANSAS RD
WEST MONROE, LA 71291
PHONE: 318-397-700
FAX: 318-737-7203

- ○ Complete Records from _____
- ○ History & Physical, Progress Notes, Medication Record, Treatment Records
- ○ Lab Reports, Radiology Reports, Pathology Reports
- ○ Immunization Records
- ○ Hospital Reports
- ○ Other (please specify) _____

Patient Name: _____ D.O.B. _____

Parent/Guardian Name: _____

Relation to patient if less than 18 years of age _____

_____

(Patient, Parent, or Legal Guardian Signature)

_____

Date

(This authorization shall expire on December 31, 2020)