PELICAN MEDICAL

6473 HWY 44 SUITE 103 GONZALES, LA 70737 PH: (225)257-1040 FAX: (225)257-1043

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____

Date of Birth ____/____/_____ SSN: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT: _____ Phone: _____

Relationship to patient: _____

Preferred pharmacy: _____

How did you hear about us? _____

DO YOU HAVE A LIVING WILL? ◯ YES ◯ NO HEALTHCARE POWER OF ATTORNEY? ◯ YES ◯ NO

PLEASE CIRCLE ONE:

GENDER: MALE / FEMALE _____

RACE: African American / White / Hispanic/Latino / Other _____

ETHNICITY: Hispanic/Latino/Not Hispanic/Latino _____

PREFERRED LANGUAGE: English/Spanish / Other: _____

MARITAL STATUS: Married / Single / Widowed / Divorced / Separated

Custodial Parent / Guarantor / Responsible Party (For patients under the age of 18)

Last Name: _____ First Name: _____

Relationship to patient: _____ DOB: _____ SS#: _____

Phone# : _____ Employer: _____

Address: _____

VERIFICATION: I verify that the above information provided is true and correct to the best of my knowledge:

X_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

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HIPAA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that I have been provided the opportunity to receive a copy of the Notice of Privacy that explains when, where and why my confidential health information may be shared. I acknowledge that Pelican Medical Wellness and Cosmetic Center, the provider, the nurses and other staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Pelican Medical Wellness and Cosmetic Center operations and responsibilities.

CONSENT FOR TREATMENT

I hereby consent to all medical treatments, procedures, medical photographs (digital or other images) deemed necessary by the provider. I also agree to electronic prescribing of my prescriptions, and retrieval of prescription history. I acknowledge that there is no guarantee as to the results of the procedures and medical treatments performed. A copy of this authorization may be used in place of the original. I certify that the information I have provided is true and correct. I am aware that knowingly providing false information regarding my identity, insurance coverage, etc. constitutes as fraud.

CONSENT FOR ELECTRONIC COMMUNICATION

I hereby consent to receive SMS text and email appointment reminders, as well as messages from my provider, through the patient portal of my electronic health record.

_____ _____

X Signature of Patient or Authorized Representative Date

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PATIENT NO CALL/ NO SHOW APPOINTMENT POLICY

Thank you for trusting your medical care to Pelican Medical Wellness and Cosmetic Center. When scheduling an appointment with our office we reserve a time specifically for you! Should the need arise to cancel or reschedule your appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us the opportunity to provide other patients an appointment.

- Any patient (new or established) that fails to show up for their scheduled appointment will be considered a No Show. We will attempt one courtesy call to try and reschedule the missed appointment.

- A Second No Call No Show for a scheduled appointment will result in Pelican Medical Wellness and Cosmetic Center not scheduling any additional appointments. You will have the option to be seen as a "Walk-In" only, and while we will always do our best to fit you in to our schedule that day, we can't make any guarantees that you will be seen that day. Also, we will not be able to provide you with an estimated wait time for any walk-in office visits.

- Your insurance provider may also be notified that you have not been compliant with your scheduled appointments and/or our appointment policy. This may negatively impact your agreement with your insurance company as it essentially deprives you of your needed healthcare as well as prevents other patients from being seen for their healthcare needs.

As a courtesy, we make reminder calls for appointments the day before and on the Saturday for our Monday appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We also STRONGLY encourage all patients to sign up for the patient portal. In addition to a reminder phone call the day before your appointment, a reminder email will be sent one week as well as one day before your appointment. Please provide a working email address upon check in and accept the invitation received via Practice Fusion.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. We will be happy to reschedule this appointment for you when you call our office and notify us of the need to cancel. We simply ask that you understand the many negative impacts that NO CALL NO SHOW appointments have on our practice, providers, other patients and you – our valued patients.

_____ _____

X Signature of Patient or Authorized Representative Date

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Authorization To Release Protected Health Information

Patient Name: _____ **DOB :** _____ **SSN:**_____

◯ Requesting From ◯ Release To ◯ Requesting From ◯ Release To

Pelican Medical Wellness and Cosmetic Center
6473 Hwy 44 Ste 103
Gonzales, LA70737 FAX: 225-257-1043

_____
_____
_____

I request and authorize the above-named healthcare provider to disclose the medical information specified below to the organization, agency, or individual on this request.

Information to be disclosed: _____

Purpose of disclosure: _____ **DOS:** _____

I understand that the information released may include information regarding the following conditions:

☐ Drug and/or alcohol abuse ☐ AIDS/HIV/STD ☐ Psychological/Psychiatric conditions and/or treatment

Authorization: I certify that this request is made voluntarily, and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. This authorization will expire in _____ days unless revoked at an earlier time. Re-disclosure of my medical information by those I hereby authorize to receive the above specifications information should not be made without my further written consent. I agree that the healthcare provider is not responsible for the misuse and cannot guarantee the confidentiality of medical information once it is released to another party. I hereby release the healthcare provider from any liability, which may result from furnishing the information requested as authorized. A copy of this authorization will be as valid as the original.

_____ _____
X Signature of Patient or Authorized Representative **Date**

_____ _____
Witness **Date**

PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2, A general authorization of the release of medical or other information is NOT SUFFICIENT FOR THIS PURPOSE. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Name:_____ **Date:**_____ **Reason for this visit**_____

ALLERGIES(include drugs, food, latex, plants/chemicals) _____

_____

_____

PERSONAL HEALTH HISTORY MEDICATIONS(include name, dose, how often taken & any over the counter medications, vitamins and supplements:_____

_____

_____

_____

_____

CURRENT OR PAST MEDICAL PROBLEMS:

- ADD/ADHD
- Allergies/Sinus
- Anemia
- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Blood Clotting Disorder
- Bradycardia
- Cancer (specify) _____
- Chest pain
- Chronic Bronchitis
- Emphysema/COPD
- Chronic Pain
- Constipation
- Degenerative Disc Disease
- Degenerative Joint Disease
- Depression
- Diabetes
- Diverticulitis
- Dizziness/Vertigo
- Ear Disorder (specify) _____
- Eating Disorder
- Epilepsy/Seizures
- Erectile dysfunction
- Gout
- Hearing Loss
- Heart Attack
- Heart Failure
- Hemorrhoids
- Hepatitis
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- IBD (Crohn's/Ulcerative
- Colitis
- Kidney Failure
- Kidney Stone
- Leg Swelling
- Meniere's Disease
- Nerve pain/neuropathy
- Pancreatitis
- Peripheral Vascular Disease
- Prostate Problems
- Reflux/GERD
- Skin Disorder (specify) _____
- Stroke
- Substance Abuse/ Alcoholism
- Tachycardia
- Thyroid Disorder
- Tuberculosis
- Ulcers
- Other _____ _____

SURGERIES:

- Adenoidectomy
- Angioplasty
- Appendectomy
- Back Surgery
- Bladder Scope/Surgery
- C-section
- CABG
- Cancer removal
- Cardiac Stents
- Cataract Removal
- Colon Surgery/Removal
- Defibrillator implanted
- Dialysis Access
- Endoscope (EGD)
- Esophageal Surgery
- Fundoplication
- Gallbladder Removal
- Gastric Bypass
- Heart Valve Surgery
- Hernia Repair (specify) _____
- Hysterectomy (Total / Partial)
- Joint replacement
- Liver Surgery/Biopsy
- Lung Surgery/Biopsy
- Mastectomy
- Neck Surgery
- Orthopedic Surgery
- Pacemaker Implanted
- Sinus Surgery
- Splenectomy
- Tonsillectomy
- Tracheostomy
- Tubes Tied
- Vasectomy
- VP Shunt

List any other surgeries or procedures:

FAMILY HISTORY (list major illness, cancer, diabetes, heart disease, etc):

Mom:_____ **Mom's Mom**_____ **Mom's Dad**_____

Dad:_____ **Dad's Mom**_____ **Dad's Dad**_____

Siblings: _____**Children:**_____

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PREVENTIVE CARE/SCREENINGS:	DOCTOR:	YEAR:
COLONOSCOPY		
BONE DENSITY/DEXA		
MAMMOGRAM		
PAP SMEAR		
DIGITAL RECTAL EXAM (PROSTATE EXAM)		
MRI/CT/X-RAY (SPECIFY TYPE)		
FLU SHOT		
PNEUMONIA SHOT (13 / 23)		
TETANUS SHOT		

WHO WAS YOUR PREVIOUS PCP?_____

WHAT SPECIALISTS DO YOU SEE? _____

HEALTH HABITS AND LIFESTYLE: (please circle/list type and amount of each and how often)

Caffeine (chocolate, soda, tea, coffee): ◯ yes ◯ no If yes how much?_____

Tobacco (cigarettes, smokeless tobacco, vape/e-cig) ◯ yes ◯ no If yes how much? _____

Recreational/Street Drugs (marijuana, cocaine, prescriptions, stimulants, other) ◯ yes ◯ no

If yes, how much and how often? _____

Alcohol (beer, wine, liquor) ◯ yes ◯ no If yes how much? _____

Are you concerned about how much you consume? ◯ Yes ◯ No

Exercise? ◯ Yes ◯ No How often? _____ Type of Exercise:_____