**Dr. Richard Duplantis**
322 Heymann Blvd, Suite 2
Lafayette, LA 70503
(337) 350-0225

# CONFIDENTIAL PATIENT INFORMATION

**PLEASE PRINT**

**PATIENT INFORMATION:** DATE: ____________

NAME ________________________________ DATE OF BIRTH ___/___/_____ AGE____

MALE ◯ FEMALE ◯ SSN ____-___-______ MARITAL STATUS (S/M/W/D): ________________

ADDRESS______________________________________________________ APT# _____________

CITY______________________________ STATE______________ ZIP CODE __________-_______

HOME PHONE: (____)_____-_______ CELL: (____)_____-_______ WORK: (____)_____-_______

EMAIL ADDRESS: __________________________________________________________________

EMERGENCY CONTACT: ___________________________________ PHONE __________________

EMPLOYER'S NAME: _________________________________ OCCUPATION__________________

WORK ADDRESS _______________________________________________BLDG/SUITE#_________

CITY______________________________ STATE______________ ZIP CODE __________-_______

HOW DID YOU HEAR ABOUT US? _____________________________________________________

PRIMARY REASON FOR VISIT _________________________________________________________

DATE OF INJURY __________________________________________________________________

DATE SYMPTOMS BEGAN ____________________________________________________________

HAVE YOU SEEN ANY OTHER PHYSICIANS, PHYSICAL THERAPISTS, CHIROPRACTORS OR OTHER CLINICIANS FOR TREATMENT OF THIS CONDITION?

◯ YES ◯ NO IF YES, PLEASE PROVIDE PROVIDER NAME AND DATE RANGE OF TREATMENT

PROVIDER NAME___________________________TREATMENT DATE RANGE_____________________

## CLAIM INFORMATION:

IS YOUR CONDITION DUE TO: ◯ AUTO ACCIDENT ◯ PERSONAL INJURY ◯ WORK INJURY

OTHER ◯ IF OTHER, PLEASE EXPLAIN: ____________________________________________________

TYPE OF CLAIM ◯ CASH ◯ GROUP HEALTH INS ◯ ATTORNEY ◯ WORKER'S COMP ◯ MEDICARE

I WILL BE PAYING TODAY BY: ◯ CASH ◯ CHECK ◯ CREDIT/DEBIT CARD (TYPE_____________________)

OTHER ◯ IF OTHER, PLEASE EXPLAIN: _____________________________________________________

## INSURANCE INFORMATION:

RELATIONSHIP TO INSURED ◯ SELF ◯ SPOUSE ◯ CHILD ◯ OTHER ________________________

INSURED'S EMPLOYER - SAME AS ABOVE ◯ ________________________________________________________

INSURED'S SSN AND DATE OF BIRTH- SAME AS ABOVE ◯ SSN ___-__-____ DATE OF BIRTH ___/___/____

**PRIMARY INSURANCE CO**. __________________________________ ADDRESS ___________________________

CITY _________________________ STATE __________ ZIP CODE_______ PHONE (___) _________________

POLICY NUMBER_________________________________ GROUP NUMBER ________________________________

**SECONDARY INSURANCE CO**. _________________________________ADDRESS ___________________________

CITY _________________________ STATE __________ ZIP CODE_______ PHONE (___) _________________

POLICY NUMBER_________________________________ GROUP NUMBER ________________________________

## AUTHORIZATIONS:

- I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all serviced rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature ________________________________________________ Date ______________________

Guardian Signature _____________________________________________ Date ______________________