

PELICAN STATE OUTPATIENT CENTER

1525 Dickory Ave, Harahan, La 70123

Phone: 504-818-0006

Fax: 504-818-0095

PATIENT INFORMATION

\*\*\*PLEASE PRINT

Patient Last Name First Middle Date of Birth Sex: M F
Title: Mr/Ms/Mrs Other Suffix: Jr/Sr/Other Social Security #
Mailing Address Marital Status: Married Single Widowed Divorced
City State Zip Student: Full-time Part-time Not a student
Home Ph# Cell Ph# Employment: Full-time Part-time Retired
Work# Employer Self-Employed Unemployed Military
Emergency Contact Name Phone # Relationship

PRIMARY POLICYHOLDER/RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE:

INSURANCE NAME & ADDRESS:

POLICY #/ CONTRACT#/ MEMBER ID#:

PRIMARY POLICYHOLDER'S NAME:

MAILING ADDRESS: CITY/STATE ZIP

HOME PHONE#: WORK#: EMPLOYER

DATE OF BIRTH: SOCIAL SECURITY#:

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER SEX: M F

SECONDARY INSURANCE:

INSURANCE NAME & ADDRESS:

POLICY #/ CONTRACT#/ MEMBER ID#:

PRIMARY POLICYHOLDER'S NAME:

MAILING ADDRESS: CITY/STATE ZIP

HOME PHONE#: WORK#: EMPLOYER

DATE OF BIRTH: SOCIAL SECURITY#:

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER SEX: M F

AUTHORIZATION FOR TREATMENT

I hereby certify that the personal medical information submitted is correct and that I seek medical treatment from Pelican State Outpatient Center and its staff. I hereby authorize such treatment so deemed appropriate and necessary by the physician.

WORKER'S COMPENSATION

We must be able to verify and obtain authorization for all services rendered to patients covered by a worker's compensation insurer. If we are unable to verify coverage, you will be notified prior to the visit or procedure and full payment at time of service is expected.

LEGAL CASES

You must pay before services are rendered, unless other arrangements are made in advance.

RELEASE OF INFORMATION

I authorize Pelican State Outpatient Center to furnish information to insurance carriers, employers, referring physicians, or other medical consultants concerning the illness and treatments for myself or my dependents.

I hereby authorize the above-listed insurance companies to pay directly to PSOC benefits due me, if any, as provided in the above unexpired policy. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENTS ON COPAYS, DEDUCTIBLES, CO-INSURANCE, ANY CHARGES AND/OR CLAIMS THAT ARE NOT COVERED AND/OR NOT PAID BY THE INSURANCE COMPANY WITHIN 60 DAYS.

SIGNATURE NAME DATE