PELICAN STATE OUTPATIENT CENTER

1525 Dickory Ave, Harahan, La 70123
Phone: 504-818-0006 Fax: 504-818-0095

PATIENT INFORMATION

***PLEASE PRINT

Patient _____ Date of Birth _____ Sex: M F
Last Name First Middle
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 _____

Preferred Pharmacy w/address & phone #: _____

Patient's email address: _____

POLICYHOLDER/RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE:
INSURANCE NAME & POLICY #: _____

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 & POLICY #: _____

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. I ALSO UNDERSTAND THAT PSOC IS AN URGENT CARE CENTER AND IS CONTRACTED AS SUCH WITH INSURANCE CARRIERS.

SIGNATURE _____ NAME_____ DATE _____