



# NORTHSHORE

## FAMILY MEDICAL CENTER

### PATIENT INFORMATION

PATIENT'S NAME DATE OF BIRTH SOCIAL SECURITY #

STREET ADDRESS CITY, STATE, ZIP

HOME PHONE # CELL PHONE # WORK PHONE #

Emergency Contact & relationship: Phone #:

Pharmacies local and mail-order:

### PATIENT ALLERGIES:

### COMMUNICATION PREFERENCES

1. May we leave messages on your answering machine? YES NO
2. Would you like to receive TEXT messages? YES NO
3. May we call you at work? YES NO
4. May we leave messages with any other person? YES NO Specify who \_\_\_\_\_
5. Are we authorized to release your medical information to your spouse? YES NO

### PATIENT PORTAL AND EMAIL

By giving us your email address you are agreeing to allow us to **email appointment reminders, lab letters, visit summaries and test reminders.** We will use your email address to grant access to the NORTHSHORE FAMILY PATIENT PORTAL.

EMAIL ADDRESS: (please print ): \_\_\_\_\_

The patient portal allows you to securely communicate with our staff. You can:

- Send Messages to your nurse
- View Health information as it becomes available
- Request appointments

### PATIENT CONSENT FOR TREATMENT

1. I consent to the use and disclosure of my/the patient's protected health information for the purposes of obtaining payment for services rendered to me/the patient.
2. I authorize payments to Northshore Family Medical Center/Family Medicine Billing of SMH for services rendered.
3. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.
4. I also give permission for sharing and obtaining my health information via the Carequality Network which connects to local hospitals.
5. Co pays and deductibles are due at the time of the visit.
6. There is a \$ 25.00 charge for late cancellations and No show appointments.

PATIENT OR AUTHORIZED PERSONS SIGNATURE

TODAY'S DATE



# NORTHSHORE FAMILY MEDICAL CENTER

**PATIENT NAME:**

**DATE OF BIRTH:**

Lab of choice:      LabCorp                      Quest                      *Quest is in our office- It is important to use ONE of these Labs!*

Language:

Race:      \_\_\_ Asian      \_\_\_ Black      \_\_\_ Hispanic/Latino      \_\_\_ White      \_\_\_ Do not wish to report

Ethnicity:      \_\_\_ Hispanic or Latino      \_\_\_ Not Hispanic or Latino      \_\_\_ Do not wish to report

Do you have a living will?      \_\_\_ YES      \_\_\_ NO                      *If yes -please provide us a copy at your convenience.*

(A living will tells your doctor what kind of care you would like to have if you are unable to make medical decisions.)

**THIS IS A COPY OF OUR HEALTH INFORMATION AND DISCLOSURE -WE HAVE CAPTURED YOUR SIGNATURE ELECTRONICALLY**

Northshore Family Medical Center generates and maintains paper and electronic health records, to describe your health history, symptoms, examinations, test results, diagnoses, treatments and as a record of your medications and medication history.

**How we use your medical records:**

- \* A means of sharing information among your doctors, nurses and pharmacists.
- \* **\*\*This includes sharing LAB RESULTS and TEST RESULTS with other providers.**
- \* We will also request information from other providers in your circle of care.
- \* A source of information for paying for treatment.
- \* A means to verify that services billed were actually provided.
- \* Your Prescription history updated and accessed from centralized database.
- \* A tool for routine evaluation of healthcare professionals.

**I understand that I have the following rights and privileges under federal regulations.**

- \* \* The right to review the complete notice before signing this consent.
- \* \* A copy is at the front desk or our website. [www.northshorefamily.net](http://www.northshorefamily.net)
- \* \* The right to limit how my health information may be used.
- \* \* The right to limit my health plans access to certain information.
- \* \* The right to a copy of my electronic health record.

I understand that Northshore Family Medical Center is not required to agree to the restrictions requested, and that I may take back this consent in writing.

I also understand that by refusing to sign this consent or taking back this consent Northshore Family Medical Center may refuse to treat me- as permitted by Section 164.506 of the Code of Federal Regulation.



# NORTHSHORE FAMILY MEDICAL CENTER

Please print and  
bring with you to  
your visit.

Today's Date

## PAST MEDICAL HISTORY

Previous Diagnosis(es):

## PATIENT INFORMATION

Patient's Name:

Social Security #:

Date of Birth:

Home Phone #:

Cell Phone #:

Work Phone #:

Street Address:

City, State Zip:

**Account Guarantor Name:**

Guarantor Address:

Guarantor Date of Birth:

Guarantor SS #

Marital Status:

Spouse's Name

Previous Surgeries:

Family History:

## PREVIOUS MEDICAL TESTS

Bone Density Year?:

Colonoscopy Year?:

Eye Exam Year?:

Mammogram Year?:

Pap Smear Year?:

PSA Year?:

## IMMUNIZATION HISTORY

Pneumonia Vaccine Year?:

Shingles Vaccine Year?:

Tetanus Vaccine Year?

## ALLERGIES

Medication Allergies:

Environmental or Food Allergies:

**Tobacco Use:**

Packs per day?

How many years?

**Alcohol Use:**

Drinks per day?

**Other Drug Use:**

**Other Doctors You See ?**



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**I have reviewed this copy of NSFMC's Patient Privacy Rights and give my permission to Northshore Family Medical Center to use and disclose my health information as needed.**

**SIGNATURE:**

(patient or guardian)

Date



# NORTHSHORE FAMILY MEDICAL CENTER

1150 Robert Blvd. Suite 100

Slidell, LA 70458

985-646-1122

Fax 888-865-7591

## Authorization for Release of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I understand that my health care will not be affected if I do not sign this form. I understand that I may revoke this request in writing.

Patient Name	Date of Birth
Street Address	City, State and Zip
<u>Organization Providing the information</u>	<u>Person or organization receiving the information</u>
Provider Name: _____	Northshore Family Medical Center
Name of Clinic: _____	1150 Robert Blvd. Suite 100
Phone: _____	Slidell, LA 70458
Fax #: _____	985-646-1122
	Fax 888-865-7591
<b><u>Specific description of information</u></b>	
<p>*** Please send <b>ONLY</b> information from the last 2 years. (Preferred- unless deemed medically necessary.)</p> <p>_____</p> <p>_____ Other (please specify) _____</p> <p>_____ Exclude drug, alcohol or psychiatric information</p>	
What is the purpose of the use or disclosure?	I understand this authorization expires on _____ Or in 6 months, whichever occurs first.
Signature	Today's Date
NSFMC office staff use:	
Date request was faxed _____	
Records received _____	



# NORTHSHORE FAMILY MEDICAL CENTER

1150 Robert Blvd. Suite 100 Slidell, LA 70458 985-646-1122

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

I give my permission for Northshore Family Medical Center to request and share my medical information with these providers. Medical Information including:

\_\_\_\_\_

- OFFICE NOTES
- LABORATORY RESULTS
- APPOINTMENT INFORMATION
- EYE Examinations
- TEST RESULTS Imaging and Lab
- MEDICAL OPINIONS
- TREATMENT PLANS
- HOSPITAL including DC summary

## My Doctors Names

• Eye Doctor:	Last Visit
• GI (Gastroenterology) Doctor:	Last Visit
• Gynecologist:	Last Visit
• Cardiologist:	Last Visit
• Pulmonologist:	Last Visit
• Rheumatologist:	Last Visit
• Neurologist:	Last Visit
• Home Health/Hospital:	Last Visit
• Endocrinologist or OTHER:	

PATIENT SIGNATURE \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

I understand that I may revoke this consent at any time. It expires 365 days from date, unless sooner is specified.

**Please fax records to 888-865-7591**