



# 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

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 from these listed 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**