PLEASE PRINT AND BRING WITH YOU TO YOUR VISIT.

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 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