# Mark C. Mouton, MD

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**Patient Information:**

Today's Date: ________________

Name: ___________________________________________ Date of Birth: ________________

Social Security Number: _____-_____-_____ Age: ______ Gender: [ ] Male [ ] Female

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

Address: ___________________________________________________________________

City/State: _____________________________________ Zip Code: _________________

E-Mail Address: ___________________________________________________________

Phone: (Home) _____-_____-_____ (Cell) _____-_____-_____ (Work) _____-_____-_____

How did you hear about us? ___________________________________________________

Emergency Contact: __________________________________ Phone: _____-_____-_____

Relationship: [ ] Spouse [ ] Parent [ ] Sibling [ ] Child [ ] Other: ____________________

Are you being seen today for a motor vehicle accident or work- related injury? _____YES ______NO

Pharmacy: _________________________________________ Phone: _____-_____-_____

Primary Insurance Carrier: ____________________________________________________

Policy Number: ________________________________ Group Number: ______________

Subscriber Name: ______________________________ Subscriber Date of Birth: _________

Secondary Insurance Carrier: __________________________________________________

Policy Number: _______________________________ Group Number: _______________

Subscriber Name: _____________________________ Subscriber Date of Birth: __________

*I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I will notify you of any change in my status in regards to the above information. I consent to the care including diagnostic procedures, examinations and treatment that the practitioner designates and considers to be necessary to treat my condition.* ***I certify that I have read all of the above information on this sheet and have answered all questions to the best of my knowledge.***

Signature: ______________________________________________ Today's Date: __________________

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# Medical History Questionnaire

**General Information-**

Name: ______________________ Date of Birth: ______________

Previous Primary Care Physician: ______________________

Do you see any medical specialist? ◯ Yes ◯ No  If yes, please list.

1.] ______________  3.] ______________
2.] ______________  4.] ______________

**Emergency Contact Information-**

Name: ______________________ Relationship: ______________

Phone Number: ______________________

**Allergies-**

Please list all drug allergies.

1.] ______________  3.] ______________
2.] ______________  4.] ______________

**Past Medical History-**

Have you ever had or do you now have, any of the following? (Please check all that apply.)

| | | | |
|---|---|---|---|
| ◯ High Blood Pressure | ◯ Emphysema | ◯ Erectile Dysfunction | ◯ ADD / ADHD |
| ◯ High Cholesterol | ◯ Sarcoidosis | ◯ Arthritis | ◯ Migraines |
| ◯ High Triglycerides | ◯ Sleep Apnea | ◯ Lupus | ◯ Seizures |
| ◯ Heart Attack | ◯ Crohn's Disease | ◯ Lower Back Pain | ◯ Strokes |
| ◯ Congestive Heart Failure | ◯ Colitis | ◯ Diabetes | ◯ Chronic Pain |
| ◯ Irregular Heart Beat | ◯ Stomach Ulcers | ◯ Thyroid Disease | ◯ Obesity |
| ◯ Blood Clots | ◯ Heart Burn | ◯ Depression | ◯ Anemia |
| ◯ Asthma | ◯ Hepatitis | ◯ Anxiety / Insomnia | |

◯ Cancer: ______________________

◯ Other: ______________________

**Past Surgical History-**

Have you had any surgical procedures in the past? If yes, please list with year of procedure.

1.] ______________  3.] ______________
2.] ______________  4.] ______________

**Life Style & Social History-**

Do you smoke? ◯ Yes ◯ No  If yes, How many packs per day? ________ Number of years smoking? ________

Do you drink alcohol? ◯ Yes ◯ No  If yes, How much per day? ________ Type of alcohol? ________

Do you use recreational drugs? ◯ Yes ◯ No  If yes, Please List: ______________

Occupation: ______________________

**Family History-**

If there is any history in your family of: (Please check all that apply.)

| | | |
|---|---|---|
| ◯ High Blood Pressure | ◯ Colon Cancer | ◯ Kidney Disease |
| ◯ High Cholesterol | ◯ Asthma / COPD | ◯ Stroke |
| ◯ Heart Disease | ◯ Diabetes | ◯ Epilepsy |
| ◯ Breast Cancer | ◯ Blood Disorder | |
| ◯ Obesity | ◯Other ______________ | |

Do you have any religious and/or cultural beliefs that potentially dictate/alter your medical treatment? ◯ Yes ◯ No

If yes, Please explain:

______________________

______________________

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## Patient Consent for Treatment & Authorization to Release Medical Information for Assignment of Health Insurance Benefits

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are no required to agree to this restriction, but if we do, we shall honor that statement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I further acknowledge that I will be responsible for the payment of all charges for professional services and/or goods received regardless of whether or not I have insurance coverage.

Patient Signature: ____________________________________________

Printed Name – Patient or Representative ___________________________

Relationship to Patient (if other than patient): ______________________

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## Health Information Release

**Date:** ________________________

**Patients Name:** ________________________________ **Date of Birth:** _________

To Whom It May Concern, I hereby authorize Dr. Mark C. Mouton and staff to discuss / furnish upon request, all information contained in my medical records to:

____________________________________________________________________

Relationship to patient: ______________________________________________________

I grant permission to:

Leave a message on voicemail ______ Home phone
______ Cell phone

**Patients Signature:** ________________________________________

**Date of Signature:** _________________________________________

Confidentiality Notice: The documents accompanying this fax transmission contain confidential information belonging to the sender. The information is intended only for the use of the individual or entity named above. If you have received this fax in error, please notify this office immediately by telephone.

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## Records Request

Date: ________________

**Patient's Name**: ________________________________________ **Date of Birth:** _______________

I hereby authorize:

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

To furnish upon request, all information contained in my medical records to Dr. Mark C. Mouton and staff. Please include:

- ☐ Office notes; inpatient, outpatient, and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries and test results.
- ☐ Laboratory records and specimens; radiology records and films.
- ☐ Prescription records and drug information related to such records.
- ☐ Other:__________________________________________________________________

I authorize release of information of the following portions of my medical record:
(Please initial all that apply)

______ Mental health    ______ Substance abuse
______ HIV/AIDS    ______ Communicable diseases

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization of if the authorization was obtained as a condition of obtaining insurance coverage.
- The practice will not condition treatment or payment based on my signing this authorization.
- The information disclosed in this authorization is may be subject to re-disclosure by the practice and no longer protected by federal law.
- I am signing this authorization freely and under no pressure from any individual to do so.
- I acknowledge that I have had an opportunity to review this authorization and understand its intended use.
- This authorization my include disclosure of information relating to ALCOHOL, DRUG ABUSE, and/or CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials in the appropriate blanks above.

Patient's Signature: ________________________________________________

Date of Signature: __________________________________________________

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# LATE ARRIVAL POLICY

We do our best to offer appointments that can accommodate your schedule. To best serve you, we have enforced the following guidelines:

To minimize your wait time and ensure that your visit is completed in a timely manner, we ask that you arrive to your visit on time. If you arrive more than 15 minutes late to your appointment, you will be asked to reschedule at a later date. We do not operate as a Walk-In clinic, therefore arriving at your appointment time is very important. We understand that delays happen, but as a courtesy to our patients, we must try to remain on schedule.

# CANCELLATION POLICY

If you are unable to keep your scheduled appointment, please contact our office at least 24 hours prior to the appointment. We reserve the right to charge for any appointments that are missed without notice.

Thank you for your understanding.

Please sign stating that you understand our policies.

Signature: ____________________________________________________________

Date: ____________________