DARRON C. McCANN, M.D — PATIENT HISTORY

Patient Name:_____ DOB:_____

Are you allergic to any medications?: ☐ YES ☐ NO

If *YES*, list all drug allergies: _____

MEDICAL HISTORY
Check all that apply

☐ High Blood Pressure	☐ High Cholesterol	☐ Hypothyroidism
☐ Diabeties Type 2	☐ Heart Disease	☐ Hyperthyroidism
☐ Diabeties Type 1	☐ Stroke	☐ Depression/Anxiety
☐ Asthma	☐ Acid Reflux	☐ ADHD
☐ Bipolar disorder	☐ Epilepsy (Seizures)	

Do you have any other medical problems that are not listed? (Specify): _____

_____

SURGICAL HISTORY
Check all that apply and provide what year the procedure took place. Please also provide the name of the suregon who did the surgery.

☐ Gallbladder Removal:	YEAR _____	SURGEON _____
☐ Appendix Removal:	YEAR _____	SURGEON _____
☐ Tonsil Removal:	YEAR _____	SURGEON _____
☐ Adenoid Removal:	YEAR _____	SURGEON _____
☐ Ear Tubes	YEAR _____	SURGEON _____
☐ Back Injections:	YEAR(S) _____	SURGEON _____
☐ Neck Injections:	YEAR(S) _____	SURGEON _____
☐ Heart Bypass:	YEAR _____	SURGEON _____
☐ Breast Augmentation	YEAR _____	SURGEON _____
☐ Breast Reduction	YEAR _____	SURGEON _____
☐ Endometrial Ablation	YEAR _____	SURGEON _____
☐ Tubal Ligation:	YEAR _____	SURGEON _____
☐ C-Section:	YEAR(S) _____	SURGEON _____
☐ Hysterectomy:	YEAR _____	SURGEON _____
☐ Partial Hysterectomy	☐ Complete Hysterectomy	
☐ Back Surgery:	YEAR _____	SURGEON _____
☐ Neck Surgery:	YEAR _____	SURGEON _____
☐ Heart Stent:	YEAR _____	SURGEON _____

Are there any other surguries you've had that is not listed? (Specify): _____

_____

PREGNANCY HISTORY
Check all that apply and fill in the corresponding blanks

Number of **full term** pregnancies: _____

Any complications?: ☐ YES ☐ NO

If *YES*, please explain: _____

Number of **ectopic** pregnancies if any: _____

Number of **miscarriages** if any: _____

DARRON C. McCANN, M.D. PATIENT HISTORY

FAMILY HISTORY

Check all that apply and indicate which family member has the medical condition. We are only worried about *PARENTS* and *SIBLINGS ONLY*

- ☐ Stomach Ulcers: _____
- ☐ High Blood Pressure: _____
- ☐ High Cholesterol: _____
- ☐ Depression/Anxiety: _____
- ☐ Blood Disorders: _____
- ☐ Heart Disease: _____
- ☐ Asthma: _____
- ☐ Stroke: _____
- ☐ Diabeties: _____
- ☐ Cancer: _____

SOCIAL HISTORY

Check all that apply and fill in the corresponding blanks

Smoker: ☐ YES ☐ NO

How many packs per day?: _____

How many years have you smoked?: _____

Former smoker: ☐ YES ☐ NO

How many years did you quit smoking? _____

Occupation: _____

If DISABLED, what year did you become disabled?: _____

HEALTH MAINTENANCE

Check all that apply and fill in the corresponding blanks

- ☐ Colonoscopy: YEAR _____ WHERE _____
- ☐ Prostate Exam: YEAR _____ WHERE _____
- ☐ Prostate Blood Work (PSA): YEAR _____ WHERE _____
- ☐ Pap Smear: YEAR _____ WHERE _____
- ☐ Mammogram: YEAR _____ WHERE _____
- ☐ Blood work: YEAR _____ WHERE _____

COVID Vaccine: ☐ Moderna ☐ Pfizer ☐ J&J

- ☐ 1st Dose DATE _____ WHERE _____
- ☐ 2nd Dose DATE _____ WHERE _____
- ☐ Booster DATE _____ WHERE _____

IMAGING

Check all that apply and fill in the corresponding blanks

- ☐ MRI YEAR _____ WHERE _____
  What part of your body: _____
- ☐ CAT Scan YEAR _____ WHERE _____
  What part of your body: _____
- ☐ X-Ray YEAR _____ WHERE _____
  What part of your body: _____

Patient: ______________________________ DOB: ______________

Medication Name	Dosage	Directions	Reason for Taking

REGISTRATION / INFORMATION FORM

PATIENT INFORMATION

NAME: _____ BIRTHDATE: _____ AGE _____

ADDRESS: _____ SEX: ❑ M ❑ F

_____ MARITAL STATUS: ❑ M ❑ S ❑ W ❑ D

TELEPHONE NO: _____ WORK NO: _____ SOCIAL SECURITY NO: _____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR BILL: _____

ADDRESS: _____ BIRTHDATE: _____

_____ SOCIAL SECURITY NO.: _____

TELEPHONE NO.: _____ RELATIONSHIP TO PATIENT: _____

PLACE OF EMPLOYMENT: _____

ADDRESS: _____ **WORK TELEPHONE NO.:** _____

CLINIC POLICY

I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED TO ME BY THIS CLINIC. (IF THE PATIENT IS UNDER 18, THE PARENT REQUESTING TREATMENT ASSUMES RESPONSIBILITY OF ALL CHARGES.) **FULL PAYMENT IS DUE AT THE TIME OF SERVICE** UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

I HEREBY ACKNOWLEDGE AND AGREE TO ACCEPT THE POLICIES STATED ABOVE.

SIGNATURE: _____ DATE: _____

PLEASE GIVE NAME AND ADDRESS OF SOMEONE WE MAY CONTACT IN CASE OF **EMERGENCY**.

NAME: _____ TELEPHONE NO.: _____

ADDRESS: _____

INSURANCE INFORMATION

Patient's Medicare No:	Patient's Medicaid No.:	Date of Eligibility:
WORKMAN'S COMP. (For On The Job Injuries) Date of Accident:		
Company Name:		
Primary Insurance Name and Address:	Secondary Insurance Name and Address:	
Insured:	Insured:	
(Name on ID Card)	(Name on ID Card)	
Relationship to Patient:	Relationship to Patient:	
❑ Self ❑ Spouse ❑ Child ❑ Other	❑ Self ❑ Spouse ❑ Child ❑ Other	
Insured ID No.:	Insured ID No.:	
Group No. or Company Name:	Group No. or Company Name:	
Effective Date:	Effective Date:	

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.** I understand that I (responsible party) am responsible for my portion of my bill not covered by insurance.

_____ _____

Signature of patient or authorized person Date

HOW DID YOU LEARN ABOUT OUR CLINIC? ❑ FAMILY ❑ FRIENDS ❑ DOCTOR REFERRAL:

AUTHORIZATION FOR MEDICAL CARE:

Permission is hereby granted for medical care, as may be advisable or necessary by the attending physician of this Clinic.
I understand that the Clinic will NOT be responsible for hospitalization charges, nor will it be responsible for other services unless specifically authorized.
I agree that I have read and understand the above consent and will accept its terms.

_____ _____

SIGNATURE OF PATIENT / PARENT / GUARDIAN SIGNATURE OF WITNESS

DARRON C. MCCANN, M.D.

424 N. WASHINGTON STREET MARKSVILLE, LA 71351 PHONE (318)253-1788 FAX (318)253-1787

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about you general medical condition and your diagnosis (including treatment, payment, and health operations).

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGANCY:

_____

_____

III. Please print the address of where you would like your correspondence from our office to be sent if other than your home.

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "Confidential":

_____YES NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and imaging results, and other health care information if other than your home phone number:

_____

I am fully aware that a cell phone is not a secure and private line.

VI. Can confidential messages be left on your telephone answering machine?

_____YES NO_____

VII. I am fully aware my health information can be transmitted by electronic transmission, by fax transmittal, by internet, or by e-mail.

_____ _____

Patient Signature/Legal Guardian Date

DARRON C. MCCANN, M.D.

424 N. WASHINGTON STREET MARKSVILLE, LA 71351 PHONE (318)253-1788 FAX (318)253-1787

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Darron McCann, M.D**. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Darron McCann, M.D.**'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Darron McCann, M.D.** reserves the right to revise his Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Darron C. McCann, M.D.
Privacy Officer
424 N. Washington Street Suite A.,
Marksville, LA 71351.

With my consent, **Darron McCann, M.D.** may call my home, or other designated location, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others.

With my consent, **Darron McCann, M.D.** may mail to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With my consent **Darron McCann, M.D.** may e-mail to my designated e-mail address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Darron McCann, M.D.** restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Darron McCann, M.D.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Darron McCann, M.D.** may decline to provide treatment to me.

I did receive a copy of the Patient Consent Form and Notice of the Privacy Practices.

_____ _____

Patient's Name Date

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME:		DOB:
ADDRESS:	SSN:	
CITY:	STATE:	ZIP:

PROVIDER RECEIVING PHI	ENTITY RELEASING PHI	
Darron C. McCann, M.D. 424 N. Washington St. Marksville, LA 71351 Telephone: 318-253-1788 Fax: 318-253-1787	NAME:	
	ADDRESS:	
	CITY:	
	STATE:	ZIP:
	PHONE:	FAX:

This authorization will expire on the following date or event:

DATE:	EVENT:

Purpose of this disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

	DESCRIPTION	START DATE	END DATE
☐	ALL PHI IN RECORD		
☐	PROGRESS NOTES		
☐	LABORATORY RESULTS		
☐	RADIOLOGY REPORTS		
☐	HISTORY AND PHYSICAL EXAM		
☐	DISCHARGE SUMMARY		
☐	CONSULTATION REPORTS		
☐	ITEMIZED BILLING STATEMENT		
☐	OTHER		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Psychiatric or mental care/treatment
[ ] Alcohol, drug, or substance abuse treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1.) I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY
2.) MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION
3.) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WIRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION
4.) IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MY BE DISCLOSED
5.) I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT

SIGNATURE OF PATIENT: SIGN ONLY	DATE:
SIGNATURE OF PATIENT'S REPRESENTATIVE (IF NECESSARY):	DATE:
PERSONAL REPRESENTATIVE'S RELATIONSHIP TO PATIENT:	