

Patient Name: _____

DOB: _____

Are you allergic to any medications?: YES NO

If YES, list all drug allergies: _____

MEDICAL HISTORY		
Check all that apply		
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Diabetes Type 2	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Diabetes Type 1	<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Asthma	<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> ADHD
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> 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 surgeon who did the surgery.		
<input type="checkbox"/> Gallbladder Removal:	YEAR _____	SURGEON _____
<input type="checkbox"/> Appendix Removal:	YEAR _____	SURGEON _____
<input type="checkbox"/> Tonsil Removal:	YEAR _____	SURGEON _____
<input type="checkbox"/> Adenoid Removal:	YEAR _____	SURGEON _____
<input type="checkbox"/> Ear Tubes	YEAR _____	SURGEON _____
<input type="checkbox"/> Back Injections:	YEAR(S) _____	SURGEON _____
<input type="checkbox"/> Neck Injections:	YEAR(S) _____	SURGEON _____
<input type="checkbox"/> Heart Bypass:	YEAR _____	SURGEON _____
<input type="checkbox"/> Breast Augmentation	YEAR _____	SURGEON _____
<input type="checkbox"/> Breast Reduction	YEAR _____	SURGEON _____
<input type="checkbox"/> Endometrial Ablation	YEAR _____	SURGEON _____
<input type="checkbox"/> Tubal Ligation:	YEAR _____	SURGEON _____
<input type="checkbox"/> C-Section:	YEAR(S) _____	SURGEON _____
<input type="checkbox"/> Hysterectomy:	YEAR _____	SURGEON _____
<input type="checkbox"/> Partial Hysterectomy	<input type="checkbox"/> Complete Hysterectomy	
<input type="checkbox"/> Back Surgery:	YEAR _____	SURGEON _____
<input type="checkbox"/> Neck Surgery:	YEAR _____	SURGEON _____
<input type="checkbox"/> Heart Stent:	YEAR _____	SURGEON _____

Are there any other surgeries 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?:	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please explain:	_____
Number of ectopic pregnancies if any:	_____
Number of miscarriages if any:	_____

FAMILY HISTORY

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

- | | |
|---|--|
| <input type="checkbox"/> Stomach Ulcers: _____ | <input type="checkbox"/> Asthma: _____ |
| <input type="checkbox"/> High Blood Pressure: _____ | <input type="checkbox"/> Stroke: _____ |
| <input type="checkbox"/> High Cholesterol: _____ | <input type="checkbox"/> Diabetes: _____ |
| <input type="checkbox"/> Depression/Anxiety: _____ | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Blood Disorders: _____ | |
| <input type="checkbox"/> Heart Disease: _____ | |

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

- | | | |
|---|----------------------------------|---------------------------------|
| <input type="checkbox"/> Colonoscopy: | YEAR _____ | WHERE _____ |
| <input type="checkbox"/> Prostate Exam: | YEAR _____ | WHERE _____ |
| <input type="checkbox"/> Prostate Blood Work (PSA): | YEAR _____ | WHERE _____ |
| <input type="checkbox"/> Pap Smear: | YEAR _____ | WHERE _____ |
| <input type="checkbox"/> Mammogram: | YEAR _____ | WHERE _____ |
| <input type="checkbox"/> Blood work: | YEAR _____ | WHERE _____ |
| COVID Vaccine: | <input type="checkbox"/> Moderna | <input type="checkbox"/> Pfizer |
| | <input type="checkbox"/> J&J | |
| <input type="checkbox"/> 1st Dose | DATE _____ | WHERE _____ |
| <input type="checkbox"/> 2nd Dose | DATE _____ | WHERE _____ |
| <input type="checkbox"/> Booster | DATE _____ | WHERE _____ |

IMAGING

Check all that apply and fill in the corresponding blanks

- | | | |
|-----------------------------------|-------------------------------|-------------|
| <input type="checkbox"/> MRI | YEAR _____ | WHERE _____ |
| | What part of your body: _____ | |
| <input type="checkbox"/> CAT Scan | YEAR _____ | WHERE _____ |
| | What part of your body: _____ | |
| <input type="checkbox"/> X-Ray | YEAR _____ | WHERE _____ |
| | What part of your body: _____ | |

REGISTRATION/INFORMATION FORM

PATIENT INFORMATION

NAME: _____ BIRTHDATE: _____
 ADDRESS: _____ CITY: _____
 STATE: _____ ZIPCODE: _____ SEX: FEMALE MALE
 TELEPHONE: _____ WORK PHONE: _____
 SOCIAL SECURITY #: _____ EMAIL: _____

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR BILL: _____ BIRTHDATE: _____
 SOCIAL SECURITY #: _____ RELATIONSHIP TO PATIENT: _____
 ADDRESS: _____ CITY: _____
 STATE: _____ ZIPCODE: _____ TELEPHONE: _____
 PLACE OF EMPLOYEMENT: _____ ADDRESS: _____
 CITY: _____ STATE: _____ ZIPCODE: _____
 WORK TELEPHONE: _____

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: _____
 ADDRESS: _____ CITY: _____
 STATE: _____ ZIPCODE: _____

INSURANCE INFORMATION

PATIENT'S MEDICARE #: _____ PATIENT'S MEDICAID #: _____ DATE OF ELIGIBILITY: _____
 WORKMAN'S COMP (FOR ON THE JOB INJURIES) DATE OF ACCIDENT: _____
 COMPANY NAME: _____

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE:	NAME OF INSURANCE:
ADDRESS TO MAIL CLAIMS:	ADDRESS TO MAIL CLAIMS:
PERSON INSURED:	PERSON INSURED:
NAME ON CARD:	NAME ON CARD:
RELATIONSHIP TO PATEINT:	RELATIONSHIP TO PATIENT:
MEMBER ID:	MEMEBER ID:
GROUP # OR COMPANY NAME:	GROUP # OR COMPANY NAME:
EFFECTIVE DATE:	EFFECTIVE DATE:

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT RO USE FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE CARRIER.

COMMERICAL INSURANCE

I HEREBY AUTHORIZE RELEASE OF INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND ASSIGN BENEFITS OTHERWISE PAYABLE TO ME O THE DOCTOR OR GROUP INDICATED ON THE CLAIM. I UNDERSTAND THAT (I RESPONSIBLE PARTY) AM RESPONSIBLEFOR 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 DOCTORS REFERRAL FACEBOOK WEBSITE

AUTHORIZATION FOR MEDICAL CARE

PERMISSION IS HEREBY GRANTED FOR MEDICAL CARE, AS MY 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 _____ DATE _____

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 EMERGENCY:

- 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	
<p style="text-align: center;">Darron C. McCann, M.D.</p> <p>Address: 424 N. Washington St. Marksville, LA 71351</p> <p>Telephone: 318-253-1788 Fax: 318-253-1787 E-Mail: clinic@drdarronmccann.com</p>		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
<input type="checkbox"/>	ALL PHI IN RECORD		
<input type="checkbox"/>	PROGRESS NOTES		
<input type="checkbox"/>	LABORATORY RESULTS		
<input type="checkbox"/>	RADIOLOGY REPORTS		
<input type="checkbox"/>	HISTORY AND PHYSICAL EXAM		
<input type="checkbox"/>	DISCHARGE SUMMARY		
<input type="checkbox"/>	CONSULTATION REPORTS		
<input type="checkbox"/>	ITEMIZED BILLING STATEMENT		
<input type="checkbox"/>	OTHER		
The following information will be released when included in the above information unless you indicate otherwise:			
<input type="checkbox"/> AIDS or HIV test results		<input type="checkbox"/> Psychiatric or mental care/treatment	
<input type="checkbox"/> Alcohol, drug, or substance abuse treatment		<input type="checkbox"/> Other (specify):	
<p>I UNDERSTAND THAT:</p> <p>1.) I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY</p> <p>2.) MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION</p> <p>3.) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING 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</p> <p>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</p> <p>5.) I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT</p>			
SIGNATURE OF PATIENT:		DATE:	
SIGNATURE OF PATIENT'S REPRESENTATIVE (IF NECESSARY):		DATE:	
PERSONAL REPRESENTATIVE'S RELATIONSHIP TO PATIENT:			