DEMOGRAPHICS INTAKE FORM

Hebert Medical Group, APMC

LOC: EU JE LA OE AE AJ AS PT

Acct #: _____ ☐ ABN Form ☐ Accident/Injury Information Form Completed Date: _____

P-INS Code: _____ S-INS Code: _____ F/C: _____ ☐ Request for Confidential Communications Attached

PATIENT INFORMATION

Prefix:
Mr./Mrs./Other: _____ Patient*⇳: _____ (Last) _____ (First) _____ (Middle)

Suffix: Jr./Sr./Other: _____ Previous Name: _____

Mailing Address: _____ (If PO Box, complete Street Address Below) _____ (City) _____ (State) _____ (Zip)

Street
Address: _____ _____ (City) _____ (State) _____ (Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Circle the preferred phone #/email contact. Leave message at what phone number? ☐ Home ☐ Work ☐ Cell ☐ None

Email: _____

Marital Status*: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Date of Birth*: _____ Social Security#: _____

Employer: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired _____ (MMDDYY) ☐ Military Active ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A Patient & Responsible Party are the same*? ☐ Yes ☐ No (complete below)

Race*: ☐ African American ☐ Caucasian/White ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language*: ☐ English ☐ Spanish ☐ Other: _____

☐ Provide copy of insurance card(s) to be scanned⇳ (if not, complete below) Do you have well care/preventative coverage for annual exams: ☐ Yes ☐ No

Primary Insurance: _____ Secondary Insurance: _____

Primary Ins Policy #: _____ Secondary Ins Policy #: _____

Group #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT (NOT SELF), THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Prefix: Mr./Mrs./Other: _____ Responsible Party: _____ (Employer Info if work related) (Last) (First) (Middle)

Suffix: Jr./Sr./Other: _____ Relationship to Patient: _____ Social Security #: _____

Mailing Address: _____ (If PO Box, complete Street Address Below) _____ (City) _____ (State) _____ (Zip)

Street Address: _____ _____ (City) _____ (State) _____ (Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Date of Birth*: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Email: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Retired ☐ Military Active ☐ Not Employed

Hebert Medical Group, APMC

LOC: EU JE LA OE AE AJ AS PT

Acct #: _____ ☐ ABN Form ☐ Accident/Injury Information Form Completed Date: _____

☐ Request for Confidential Communications Attached

Patient Name: _____ Date of Birth: _____

How were you referred to our practice: ☐ Friend/Relative ☐ Newspaper ☐ Radio ☐ Healthsource ☐ Other: _____

☐ Referred Physician: _____ Phone #: _____

Primary Care Provider (PCP): _____ Address: _____ Phone: _____

Is this an Accident or Injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

If 'Yes' to either question, request and complete an Accident/Injury Information Form (Rec'd by): (Date):

Do you have an Advanced Directive (living will, durable power of attorney)? ☐ Yes ☐ No

If 'Yes', provide copy. Rec'd by: Date:

Are you or have you been incarcerated within the last year? ☐ Yes ☐ No

If 'Yes', please provide: Facility Name: _____ Release Date: _____

By signing this form, I hereby acknowledge Hebert Medical Group (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

If below is not signed by the patient, please indicate relationship:
☐ Parent or Guardian of minor patient; ☐ Power of Attorney, Turix, Curator or Designated Personal Representative

---

_____ (Initial) I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of HEBERT MEDICAL GROUP, APMC.
Acknowledgement refused:
Efforts to obtain: _____
Reason for refusal: _____

_____ (Initial) I hereby acknowledge I have been provided with, read and understand the practice's 'No Show' policy and I understand that I will be charged the current fee for each no show appointment.

_____ (Initial) I hereby authorize Hebert Medical Group to evaluate and recommend any testing and/or additional treatment from other facilities, i.e., labs; who will in turn bill me for their services. I understand I have the right to refuse any such recommendations/treatment.

_____ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify all above information is true and accurate as of the below indicated date.

_____ (Initial) I hereby authorize the listed insurance companies to pay directly to Hebert Medical Group benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance, i.e., my Out of Pocket (OOP) share.

_____ (Initial) I understand that any payment(s) made by me to Hebert Medical Group in the form of a check may be processed as an electronic check transaction; therefore, the funds will be debited immediately from my checking account.

_____ (Initial) I agree that Hebert Medical Group may contact me via any means that I have provided on the prior page of this form including but not limited to land lines, cell phones (text and mobile applications), and email, etc.

_____ _____
Signature ☐ Patient ☐ Responsible Party Date

OFFICE USE ONLY Provide ABN for all potentially non covered services

HMG Staff: Scan to patient demographics 'eCW/INS' folder with copy of Insurance Card/Birth Certificate/Drivers License.

* = *Required for eCW* ⟲ = *Interfaces to MEDPM*

Hebert Medical Group, APMC

LOC: EU JE LA OE AE AJ AS PT

Acct #: _____ ☐ ABN Form ☐ Accident/Injury Information Form Completed Date: _____

Patient Name: _____ Date of Birth: _____

EMERGENCY CONTACT: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Email: _____

Any special instructions: _____

_____

_____

_____

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', office staff to assist in completing a Hospice/HHA/NH/SNF Facility Information Form.

☐ Hospice/HHA/NH/SNF Facility Info Form

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

*Note: If request initiated, assign Account Status: R - HIPAA Restricted (in **MED**PM); send copy to MEDDATA.*

Please list any person(s) other than yourself, and their relationship to you, that we may discuss your medical information with:

Person:	Relation:	Phone #:
1)		
2)		
3)		
4)		
5)		

Signature: _____ Date: _____

HEBERT MEDICAL GROUP, APMC

Richard L. Hebert. II. M.D.

Diplomat of the American Board of Otolaryngology

Patient Name (please print):_____ DOB:

Weight: _____ **Height:** _____ **Annual Flu Vaccine** (please circle one): YES / NO

CHIEF COMPLAINT/ HISTORY OF ILLNESS:

What is the reason of today's visit? _____

How long have you had this problem? _____

How severe is this problem? (Please circle one): 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

How often does this problem occur?: | | Comes and goes | | Constant

What makes it better? _____

What makes it worse? _____

PAST MEDICAL HISTORY: (Please check any illnesses you have):

		Sinus Infection			COPD/ Emphysema			Seizures
		Asthma/Reactive Airway			High Blood Pressure			Kidney Disease
		Gastric/Esophageal Reflux			Stroke			Thyroid Cancer
		Stomach Ulcers			Heart Disease/ Chest Pain			Hepatitis/Liver Disease
		Allergies			Diabetes			Neck/ Back Disease

| | Cancer (please list type(s) and date(s) diagnosed):

_____

| | Others (please list): _____

PAST SURGICAL HISTORY (please check any surgeries you have had):

		Sinus Surgery			Heart Bypass/Valve			Prostate Removal
		Nasal/Septal Surgery			Coronary Angioplasty			Colon/Intestine Removal
		Tonsil & Adenoid Surgery			Carotid Artery Surgery			Removal of Breast/Lump
		Ear Surgery			Vascular Bypass			Lung Surgery
		Thyroid Surgery			Neck/Back Surgery			Gallbladder
		Brain Surgery			Joint Surgery			Appendix Removal

| | Others (please list):_____

PHARMACY PREFERENCE:_____

MEDICATIONS (please list your current medication(s) and the dose(s) you take):

_____

_____

_____

Do you take Aspirin or Ibuprofen?: YES / NO Do you take Warfarin (Coumadin)?: YES / NO

Do you take any herbal medicines?: YES / NO Have you taken steroids in the last year?: YES / NO

ALLERGIES (please list your current medication(s) and the dose(s) you take):

_____

_____

FAMILY HISTORY (Please check all illnesses that run in your family):

		Bleeding Disorder			High Blood Pressure			Migraine Headaches
		Anesthesia Reaction			Heart Disease			Endocrine Disorders
		Hearing Loss			Stroke			Sickle Cell Anemia
		Cancer			Poor Circulation			Alcoholism
		Thyroid Disease/ Cancer			Diabetes			Psychiatric Illness

| | Other (please list): _____

_____ _____

Patient Signature Date Physician Signature Date

Social History:

Have you ever used tobacco? (Please circle all that apply): Cigarettes Cigar Pipe Chew None

How much and for how long have you used tobacco?_____

How much alcohol do you drink each day?_____

How much caffeine do you drink per day?_____

List any recreational drugs you are currently using:_____

Please Circle all that apply:

ENT:

Eye Pain/Pressure	Ringing in the ears	Dizziness
Dry/itchy eyes	Ear Drainage	Facial pain/pressure
Double vision	Postnasal Drainage	Nasal Congestion
Hearing Loss	Snoring	Nose Bleeds
Headache	Hoarseness	Poor sleep

General/Constitutional:

Change in appetite

Chills

Fatigue/Weakness

Fever

Allergy/Immunology:

Allergy to dye

Hives

Itching

Ophthalmologic:

Blurred vision

Diminished visual acuity

Discharge from eye

Flashes of light in the visual field

Floaters in the visual field

Endocrine:

Excessive Sweating

Excessive thirst

Heat intolerance

Respiratory:

Chest Pain

Hemoptysis (coughing up blood)

Pain with inspiration (breathing in)

Cardiovascular:

Heart Problems

Palpitations (irregular heart beat)

Gastrointestinal:

Diarrhea

Hematemesis

Rectal bleeding

Hematology:

Easy bruising

Groin mass

Prolonged bleeding

Genitourinary:

Blood in urine

Difficulty urinating

Kidney problems

Musculoskeletal:

Joint stiffness

Leg cramps

Skin:

Photosensitivity

Rash on feet

Skin oozing

Treated with radiation (example, for acne)

Stroke

Neurologic:

Gait abnormality

Loss of strength

Paralysis of Face/Arm(s)/Leg(s)

Seizures

Psychiatric:

Anxiety or panic attacks

Auditory/visual hallucinations

Substance abuse

Depressed mood

Difficulty Sleeping

_____ _____

Patient/Representative Initials

Physician Initials

FYZICAL®
Dizziness & Fall Prevention Centers

Falls Risk Assessment

Please circle "Yes" or "No" for each statement below.

Yes (2)	No	I have fallen in the past year. *– People who have fallen once are more likely to fall again.*
Yes (2)	No	I use or have been advised to use a cane or walker to get around safely. *– People who use a cane or walker may already be at more risk of falling.*
Yes (1)	No	I sometimes feel unsteady or lose my balance when walking. *– Unsteadiness or needing support while walking are signs of poor balance.*
Yes (1)	No	I sometimes steady myself by holding onto furniture or walls. *– Needing support standing or walking are also signs of poor balance.*
Yes (1)	No	I worry about falling. *– People who are worried about falling are more likely to fall.*
Yes (1)	No	I need to push myself up from out of a chair with my hands. *– This is a sign of weak leg muscles, a major reason for falling.*
Yes (1)	No	I sometimes have trouble stepping up onto a curb. *– This is another indication of weak leg muscles.*
Yes (1)	No	I frequently have to rush to the toilet. *– Rushing to the bathroom, especially at night, increases your chance of falling.*
Yes (1)	No	I have lost some feeling in one or both of my feet. *– Numbness in your feet can cause stumbles and lead to falls.*
Yes (1)	No	The medication I take sometimes makes me feel light-headed or sleepy. *– Side effects from medication can increase your chance of falling.*
Yes (1)	No	I take medicine to help me sleep or improve my mood. *– These types of medication can oftentimes increase your chance of falling.*
Yes (1)	No	I often feel sad or depressed. *– Symptoms of depression like feeling sad or slowed down are linked to falls.*

_____ **Total**

Add up the number of points from your circled answers. If you scored 4 points or more, you may be at risk for falling. Please discuss this brochure with your doctor.

www.FYZICAL.com

FYZICAL Dizziness and Fall Prevention Center
1700 Kaliste Saloom Bld. 1, Ste. 100B
Lafayette, LA 70508
P: (337) 210-2098
F: (337) 210-2098