Frank Caillet, M.D., APMC
Obstetrics & Gynecology
4650 Ambassador Caffery Parkway
Suite 101
Lafayette, LA 70508
(337) 981-3363

Date: _____________

Patient Name: ____

Date of Birth: __________SSN: _________________Language: __________ Marital Status: ______

Race:
- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o White

Ethnicity:
- o Hispanic or Latino
- o Not Hispanic or Latino

Home Phone: _______________Cell Phone: ________________Email: _______________________

Address: ___________________________________ City: _____________ State: ____Zip: _______

Patient's Occupation: ________________ Employer: _________________ Phone: _____________

Preferred Pharmacy: _________________________________ Pharmacy Phone: ________________

Parent/Legal Guardian: ____________________________________Phone:____________________

Emergency Contact: _______________________Relationship__________ Phone #: _____________

Spouse Name: _______________________________ SSN: _________________ DOB: __________

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Insurance Information

Acct #: ________________________ Date:__________________

Patient Name: ____

Primary Insurance

Name of Insurance Co.: ____
Name on card (insured): ____
ID#/SS#: _____________________________Policy/Group#: ____________
Insured's relationship to patient: self spouse parent other:____________
Insured's place of employment: ____________________________________
Employment Phone: ____________________

Secondary Insurance

Name of Insurance Co.: ____
Name on card (insured): ____
ID#/SS#: _____________________________Policy/Group#: ____________
Insured's relationship to patient: self spouse other:____________
Insured's place of employment: ____________________________________
Employment Phone: ____________________

I hereby authorize the release of information acquired during the course of my treatment and permit payment directly to the physician. I acknowledge that the financial policy has been provided to me. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also understand that I will be responsible for all non-covered charges.

_________________________________ ____________________

Signature of Responsible Party **Date**

Contact with Patients

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As required by the Health Information Portability and Accountability Act of 1996(HIPAA), you have the right to request that communications concerning your protected health information (PHI) be made by alternative means or at an alternate location. The practice will accommodate all reasonable requests.

I wish to be contacted in the following manner (check all that apply):

Home telephone____________________________________
- Leave message with detailed information
- Leave message with call-back number only

Work telephone________________________________
- Leave message with detailed information
- Leave message with call-back number only

Written communication
- Mail to my home address
- Mail to my work/office address
- Fax to this number_____________________________

Email/Patient Portal __________________________________

Other__________________________________

We are unable to speak to anyone about your care unless you list them here.

1.____

2.____

The Practice contacts patients for a variety of reasons, including appointment reminders and test results. If you would like to restrict the way in which we contact you, please inform a member of our reception desk staff and complete this form.

_________________________________ _________________________________
Patient Signature **Date**

_________________________________ _________________________________
Patient Name **Date of Birth**