NAME____

________ADDRESS____CITY_________________________STATE______ZI

P_____________

HOME PHONE _(__________)______________________________CELL

PHONE_(__________)______________________________

EMAIL____ DATE OF

BIRTH________________________

SOCIAL SECURITY #_____________________________________ ☐ MALE ☐ FEMALE

EMPLOYER____PHONE__________________________EXT______

____

IF DIFFERENT FROM ABOVE, LIST PERSON(S) RESPONSIBLE FOR EXPENSE OF TREATMENT

NAME____

____

ADDRESS____CITY________________________STATE_______ZIP_______

______

WHO REFERRED YOU TO THIS

OFFICE?____

PLEASE HAVE INSURANCE CARD(S) AVAILABLE. A COPY OF YOUR CARD IS NEEDED TO FILE A CLAIM.

PRIMARY INSURANCE PLAN____

NAME OF INSURED ____ INSURED DATE OF
BIRTH______________
RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD

SECONDARY INSURANCE PLAN____

NAME OF INSURED ____ INSURED DATE OF
BIRTH______________
RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

FOR INSURANCE CLAIMS: I AUTHORIZE THE USE OF THIS FORM ON ALL OF MY INSURANCE SUBMISSIONS. I AUTHORIZE THE RELEASE OF INFORMATION TO ALL OF MY INSURANCE CARRIERS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIERS. I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

PRINT NAME

____

SIGNATURE____

PLEASE CHECK ALL THAT APPLY TO YOUR CURRENT HEALTH

☐HIGH BLOOD PRESSURE ☐HIGH CHOLESTEROL ☐DIABETES ☐HEART DISEASE ☐ARTHRITIS

☐ASTHMA ☐THYROID CONDITON ☐GLAUCOMA ☐ MACULAR DEGENERATION ☐CATARACTS

☐OTHER ____

PLEASE LIST CURRENT MEDICATIONS ☐NONE TAKEN

____

____

DRUG ALLERGIES ____ ☐NO KNOWN DRUG ALLERGIES

☐NEVER SMOKED ☐QUIT SMOKING __________YRS AGO ☐CURRENT SMOKER

☐ FLU VACCINE ☐ PNEUMONIA VACCINE

MEDICAL RECORDS RELEASE

DATE______________________________

TO____

I HEREBY AUTHORIZE YOU TO RELEASE TO

Brandon M. Wool, M.D.
315 Metairie Road Suite 302
Metairie, LA 70005
(504) 835-2197
Fax (504) 835-2631

ANY INFORMATION CONCERNING THE MEDICAL FINDINGS AND TREATMENT OF

DOB____

I RELEASE YOU FROM ANY LAWS RELATED TO DISCLOSURE OF CONFIDENTIAL OR PRIVILEGED INFORMATION.

SIGNATURE ____

WITNESS____

BRANDON M. WOOL, M.D.

NOTICE OF PRIVACY RIGHTS

PATIENT ____

Your Health Information may be used in the following manner:

TO PROVIDE TREATMENT Your health information (medical records) may be used to provide medical care within this office and may be shared with referring physicians, pharmacies and other health care professionals providing treatment to you.

TO OBTAIN PAYMENT We may be required by your insurance company to include a copy of your medical record to obtain payment. We may do so by filing insurance forms on your behalf and/or submitting insurance claims electronically.

PATIENT REMINDERS We may remind you of scheduled appointments and the need for follow up care. We may do this by telephone call or postcard.

FAMILY, FRIENDS OR CARETAKERS We may share your health information with those persons responsible for your daily care, treatment, medication or payment. We will always ask your permission before disclosing information.

We may be required to provide your health information without your consent for the following reasons: as required during investigation by law enforcement agencies, as required by military command authorities in matters of national security, in response to legal proceedings, to a coroner for identification purposes and as required by the US Food and Drug Administration.

PATIENT RIGHTS You have the right to request certain restrictions on the uses of disclosures of your health information. You have the right to read, review and copy your health information. You may request a copy of your health information at a charge of .25¢ per page for copying expenses. You have the right to submit your concerns to this office or the Secretary of Health and Human Services if you believe your privacy rights have been compromised.

I request the following restrictions in the use and disclosure of my health information

By signing this form, I acknowledge and agree with the policies stated within. This agreement will remain in effect without expiration. I understand that I have the right to revoke this authorization at any time.

Signature ____ Date____________________