

The Cypress Clinic

622 Cypress Street • Sulphur, LA 70663 • (337) 527-2491

Patient's Name: _____			Today's Date: _____		
Date of Birth: _____		Marital Status: _____		Sex: _____	
Address: _____			SS Number: _____		Drivers Lic. #: _____
City: _____	State: _____	Zip: _____	Home Phone: _____		Work Phone: _____
Employer: _____			Employment Status: _____		Cell Phone: _____

Responsible Party: _____			Date of Birth: _____		Sex: _____
Address: _____			SS Number: _____		Marital Status: _____
City: _____	State: _____	Zip: _____	Home Phone: _____		Drivers Lic. #: _____
Relationship to Patient: _____					Cell Phone: _____
Employer: _____			Employment Status: _____		Work Phone: _____

Health Insurance: _____			(Provide Insurance Card to Office Staff)		
Policy Number: _____		Group Number: _____			
Name of Insured: _____			Relationship to Patient: _____		
Insured Birth Date: _____			Insured Social Security #: _____		

Secondary Health Insurance: _____					
Policy Number: _____		Group Number: _____			
Name of Insured: _____			Relationship to Patient: _____		
Birth Date _____		Insured Social Security # _____			

Nearest Relative not Living with you: _____			Relationship to Patient: _____		
Address: _____		Phone: _____		Alt Phone: _____	

AUTHORIZATION AND ASSIGNMENT FOR INSURANCE PURPOSES (PLEASE SIGN BOTH)

I authorize The Cypress Clinic to disclose any information from my health record to insurance carriers for the processing of claims. I assign to The Cypress Clinic all payments for medical services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by assigned insurance. If for any reason should the account become delinquent, I agree to pay for all collection and/or legal fees.

Date: _____ Signature: _____

CONSENT TO TREATMENT:

I, the undersigned do hereby authorize The Cypress Clinic to provide medical care as may be deemed necessary in the judgment of the physician. This treatment may include but is not limited to: laboratory procedures, non-invasive diagnostic and therapeutic procedures and treatments, administration of pharmaceutical products, such as injections and intravenous medications or other therapeutic solutions, and minor surgical procedures such as wound suturing.

Date: _____ Signature: _____