Coughran Medical Group
Jimmy R. Coughran M.D.
P.O. Box 730
101 Fair Avenue
Winnsboro, LA 71295
Phone: (318) 435-8020 Fax: (318) 435-8099

We are no longer accepting chronic pain patients or adult attention deficit patients. If this is the reason for your office visit, please understand that we are not accepting patients with these medical problems.

_____ _____

Patient Signature Date

Coughran Medical Group

Jimmy R. Coughran, M.D.
Billie Jo Bailey Johnson, FNP-BC
Shelby Vascocu, FNP-C
John Ulmer, FNP-C

101 Fair Avenue
Winnsboro, LA 71295
Ph: (318) 435-8020
Fx: (318) 435-8099

New/Patient Update Information

Date: _____ Referred By: _____

Name: *(First)* _____ *(M.I.)* _____ *(Last)* _____

DOB: _____ Gender: Male or Female Race: *(Not Required)* _____

Address: _____ City: _____ State: _____ ZIP: _____

Social Security # _____ - _____ - _____ Employer: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Email: _____@_____.com

Marital Status: *(Circle One)* Single Married Divorced Widow/Widower

Legal Spouse or Guardian: _____ DOB: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ ZIP: _____

EMERGENCY INFORMATION: *(Other than spouse or guardian)*

Name: _____ Address: _____

Phone: (_____)_____ Relationship: Friend / Relative / Neighbor / Other: _____

******* Please provide us with a copy of your current driver's license or ID and insurance cards. *******

**** IF ANY CHANGES OCCUR, ESPECIALLY INSURANCE, PLEASE NOTIFY OUR OFFICE ****

If you have no insurance coverage, payment is due at the time of service. If you are insured and the clinic files your visit with your insurance company, you will be responsible for your co-pay and deductibles as outlined in your agreement with your insurance company. However, any charge that is deemed 'NOT COVERED' by your insurance company will be charged to you. In the event my account is assigned to collections, I agree to pay all costs of collection, including reasonable attorney fees. There will be a $25.00 service charge on all returned checks. A photocopy of this assignment shall be considered as valid as an original. This assignment will remain in effect until revoked by me in writing.

Signature: _____ Date: _____

I hereby authorize JIMMY R. COUGHRAN, M.D. to furnish information to my insurance carriers, concerning my illness and treatments. I also authorize the above listed physicians to receive ALL payments for medical services rendered to myself or any dependents. I understand that I am responsible for any amount not covered by insurance. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 112b of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

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MEDICAL RECORDS

By signing this document, I agree that I have received and had an opportunity to review this Notice of Privacy Practice. This authorization will remain in force until I, _____ request in writing that a change be made.

_____ _____

Patient/Guardian Signature **Date**

Patient's DOB: _____

The following is a list of all persons who may request or have access to my Personal Health Information (PHI) whether they are needing a copy of records or are calling for information on my behalf:

NAME:	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HISTORY

Name: _____ Date: _____

Phone #: (___)_____ Alternate Phone #: (___)_____

Social Security #: _____ - _____ - _____ DOB: _____

Are you allergic to any medications? Yes / No
(If yes, please list below)

_____

_____

_____

_____

Have you been recently hospitalized? Yes/No

_____

Date Reason

_____

Date Reason

List most recent surgeries:

_____

Date Type of Surgery

_____

Date Type of Surgery

_____

Date Type of Surgery

_____

Date Type of Surgery

FAMILY HISTORY

	Father	Mother	Children
Asthma	____	____	____
Bleeding Disorder	____	____	____
Cancer	____	____	____
Diabetes	____	____	____
Glaucoma	____	____	____
Epilepsy/Convulsions	____	____	____
Heart Disease	____	____	____

	Father	Mother	Children
High Blood Pressure	____	____	____
Kidney Disease	____	____	____
Mental Illness	____	____	____
Migraine	____	____	____
Osteoporosis	____	____	____
Stroke	____	____	____
Thyroid Disease	____	____	____

PATIENT HISTORY

Please answer Y or N

Fever	____	Hay Fever	____	Headache	____	Rashes	____
Weight Loss Recent	____	Hepatitis	____	Leukemia	____	Psoriasis	____
Failing Vision	____	Pneumonia	____	Allergies	____	Memory Loss	____
Eye Infections	____	Chronic Cough	____	Cancer	____	Thyroid Disease	____
Ringing in Ears	____	Asthma/Wheezing	____	Blood in Urine	____	Depression	____
Sinus Trouble	____	Peptic Ulcers	____	Kidney Stones	____		
Hypertension	____	Nausea/Vomiting	____	Venereal Disease	____		
Chest Pain	____	Abdominal Pain	____	Urethral Discharge	____		
Swelling/Ankles	____	Diarrhea	____	Muscle Weakness	____		
Indigestion	____	Constipation	____	Numbness/ Tingling	____		
Breast Cancer	____	Bloody Stool	____	Back Pain	____		
Anemia	____	Frequent Urination	____	Arthritis	____		

SOCIAL HISTORY

Name: _____ DOB: _____ Date: _____

Have you ever signed a DNR (Do Not Resuscitate) order? _____ (If yes, please provide a copy to staff.)

Does someone have Power of Attorney over you? _____ (If yes, please provide a copy to staff.)

Living Arrangements:

Live Alone _____ Live with others _____ Nursing Home _____ Home Health _____ Hospice _____

Daily Intake: (Please specify quantity on a daily basis.)

Do you use tobacco products? _____ Alcohol _____

Caffeine Intake _____ Substance Abuse _____

Occupational: (Please check all that apply.)

Agriculture _____ Construction _____ Manufacturing _____ Medical/Hospital _____ Office Work _____

Painter _____ Salesperson _____ Homemaker _____ Other Occupation _____ Exposure to Dust _____

Exposure to Noise _____ Exposure to Radioactivity _____

Daily Living: (Please check all that apply.)

Use a cane _____ Use a walker _____ Use a wheelchair _____ Use a hearing aid _____

Use a catheter for urine _____ Have problems using toilet _____ Able to drive _____

Rely on others for transportation _____ Rely on public transportation _____

Exercise: (Please check all that apply.)

Regularly _____ Occasionally _____ Rarely _____ Never _____

Foreign Travel/Living:

Have you recently lived outside of the USA _____ (if yes, where and when) _____

Have you recent traveled outside of the USA _____ (If yes, where and when) _____

Female Patients:

Total Times of Pregnancy _____ Total Live Births _____ Total Abortions _____ Miscarriages _____

Still Birth _____ Mammogram _____ PAP Smear _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

- ☐ 2 years prior from last date seen
- ☐ Dates Other: _____
- ☐ Specific Information Requested:

_____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Jimmy R. Coughran, M.D.

Address: 101 Fair Avenue

City, State, Zip: Winnsboro, La. 71295

☐ **Please mail records.**

☐ **Please fax records.**

Fax: 318-435-8099 **Phone:** 318-435-8020

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____. **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.) — **Date**

_____ _____

Printed name of Authorized Representative — Relationship / Capacity to patient

_____

Address and telephone number of authorized representative