Teche Action Board, Inc.

Patient Profile Form

Account No. _____ Medical Record No. _____ Location _____ Date: _____

A. PATIENT INFORMATION *(Please give receptionist your ID for copying)*

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Work Ph # _____ Cell/Alternate Phone # _____

E-mail Address: _____

SSN# _____ Race ____ Are you a Veteran: Yes _____ No _____ Sex at Birth _____

Sexual Orientation: Lesbian or Gay☐ Straight☐ Bisexual☐ Something Else☐ Don't Know☐ Choose not to disclose☐

Current Gender Identity: Male☐ Female☐ Transgender Female-to-Male☐ Transgender Male-to-Female☐ Other☐ Choose not to disclose☐

B. EMERGENCY CONTACT INFORMATION

Please give the name of someone we can contact in case of an emergency (please list someone not living in the home with the patient).

Contact Name: _____ Relationship to patient: _____

Address: _____ Phone Number: _____

Alternate Phone Number: _____

C. INCOME INFORMATION

Employer Name: _____ Employer's Address: _____

Gross Income: _____ How often: _____

Spouse's Employer: _____ Employer's Address: _____

Gross Income: _____ How often: _____

OTHER SOURCES OF INCOME

Do you receive any of the following (please check all that apply): SSI ____ Veterans Assistance____ AFDC(Welfare)____

Child Support ____ Social Security ____ Retirement Benefits ____ Are you receiving Food Stamps? Yes ____ No ____

Public Housing ____ Section 8 Housing ____

D. INSURANCE INFORMATION (*Please give your insurance card to the receptionist for copying)*

Insurance Company Name: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder DOB: _____Policy Holder SSN: _____

Group Number: _____ Effective Date of Coverage: _____

Medicare Number: _____ Medicaid Number: _____

E. *HOUSEHOLD INFORMATION* *(Please ask for additional paper if needed)*

Name	Date of Birth	Sex	Relationship to Patient	Social Security Number	Race

F. CERTIFICATION

I certify that the information given on this form is true and accurate to the best of my knowledge. If the information given is proven false, I understand that Teche Action Board, Inc. can disqualify me for any discounts and bill me for all services received and any services paid by Teche Action Board, Inc. I also certify that I will report any changes in income or insurance status to Teche Action Clinic immediately

_____ _____

Signature of Parent or Guardian Date Signature of Interviewer Date

G. ACKNOWLEDGEMENTS

Please Initial the following:

I acknowledge that I have received a copy of the "patient rights and responsibilities" _____
I acknowledge that I have received the "patient information brochure" _____
I acknowledge that I have been given information on Living Wills and Advance Directives _____

H. Acknowledgement of Receipt of Notice of Privacy Practice

I, _____, have received the Notice of Privacy Practices from Teche Action Board, Inc.

_____ Date: _____

Patient, Parent or Guardian Signature

I. Please contact me as follows (check at least one):

_____ Home Telephone ( ) _____
_____ Leave Message
_____ Leave message with call-back number on
_____ Do not leave message

_____ Work Telephone ( ) _____
_____ Leave message with details
_____ Leave message with call-back number only
_____ Do not leave message

_____ Written Communication
_____ Mail to my home address
_____ Mail to my work address

Cell Phone No. _____

Email Address: _____

The Joint Commission

PCMH

Your Primary Care Medical Home