East Jefferson Family Practice

DUNG MICHAEL TRAN, MD ALEX HOANG, MD CHARLIE LE, MD TAI NGUYEN, MD
BOARD CERTIFIED FAMILY MEDICINE

3848 Veterans Blvd., Suite 101, Metairie, LA 70002 • Phone: (504) 885-2505 • Fax: (504) 885-2510
EMAIL: EastJeffersonFamilyPractice@ejfponline.com
WEBSITE: www.Ejfamilypractice.com

PATIENT INFORMATION

Name: _____ Social Security____/____/____

Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female

Home Address: _____

City: _____State:_____Zip:_____

Email: _____

Home Phone: _____Cell Phone:_____Work Phone:_____

GUARDIAN/EMERGENCY INFORMATION

First Name: _____Last Name:_____

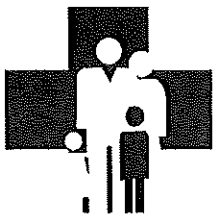
Home Address (if different from patient): _____

Relationship to Patient: _____Home Phone: _____

Cell Phone:_____Work Phone:_____

Insurance Authorization: I authorize East Jefferson Family Practice, LLC and its physicians to submit claims for services provided to me. I authorize my insurance carrier and other authorized holders of my medical information to release information needed to determine benefits payable for related services. I understand that I am financially responsible for benefits not covered by my insurance.

Signature:_____Print Name:_____Date:_____



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CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Name:_____ Date of Birth:___/___/___

Social security #:_____

I consent to medical examination by East Jefferson Family Practice physicians. I understand that additional diagnostic procedures and treatments may be recommended and will be discussed with me before they are performed. I understand that no guarantees, expressed or implied, are made regarding the results of any procedure or medical treatment.

I understand that, as part of my healthcare, this organization creates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and plans for future care.

How My Health Information May Be Used

- A basis for planning my care and treatment.
-A means of communication among healthcare professionals involved in my care.
-A source of information for documenting diagnoses and surgical information on my bill
-A means for a third-party payer to verify that services billed were actually provided.
-A tool for routine healthcare operations, such as assessing quality of care and review healthcare professionals.

My Rights

-I may object to the use of my health information for directory purposes.
-I may request restrictions on how my health information is used or disclosed for treatment, payment, or healthcare operations. the organization is not required to agree to a requested restriction.
-I may revoke this consent in writing, except to the extent the organization has already acted in reliance on it

Optional Restrictions / Disclosures

I request that disclosure of my health information be restricted to the following people and entities:

_____

_____

I allow disclosure of my health information to the following people or entities:

_____

_____

Signature:_____ Date:_____

Witness:_____ Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

You may refuse to sign this acknowledgement.

I, _____, acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other: Please specify _____

EAST JEFFERSON FAMILY PRACTICE

Dung Michael Tran, M.D. • Alex Hoang, M.D. • Charlie Le, M.D. • Tai Nguyen, M.D.
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MEDICAL HISTORY

Patient Name: _____ Date of Birth: ___ / ___ / _____

Pharmacy Name: _____ Pharmacy Phone: _____

Cross Streets: _____

1. Past Medical History

☐ Heart Disease	☐ Thyroid Disease	☐ Mood Disorder	☐ Reflux	☐ Tuberculosis
☐ Diabetes	☐ Lung Disease	☐ Gout	☐ Liver Disease	☐ Insomnia
☐ High Blood Pressure	☐ Asthma	☐ Colon Polyps	☐ Hepatitis	☐ Snoring
☐ High Cholesterol	☐ Anemia	☐ Cancer	☐ Kidney Disease	☐ Daytime Napping
☐ Stroke	☐ Osteoporosis	☐ Ulcers	☐ Sinus Allergies	

Any other major illnesses? _____

Any surgeries? _____

Names of any other doctors? _____

2. Social History

Do you smoke or use tobacco products? ☐ Yes ☐ No Started smoking at age: _____ Packs per day: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No Quit date (if applicable): _____

Current occupation: _____

3. Family History

☐ Heart Disease	☐ Breast Cancer	☐ Aneurysms	☐ Sleep Apnea	☐ Diabetes
☐ Colon Cancer	☐ Thyroid Disease	☐ High Blood Pressure	☐ Skin Cancer	☐ Mental Disorder
☐ High Cholesterol	☐ Prostate Cancer	☐ Drug Abuse	☐ Stroke	☐ Alcohol Abuse

Other family history: _____

Allergies: _____

5. Medications

Please list the medication name, strength, and how often you take it.

Medication	Strength	Times per day

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PREVENTIVE HEALTH QUESTIONNAIRE

Last Name: _____ First Name: _____

Date of Birth: ____ / ____ / _____ Height: _____ Weight: _____

Most Recent Preventive Health Measures

Measure	Month	Year
Eye Exam		
COVID-19 Vaccine (type: _____)		
Pneumonia-13 Vaccine		
Pneumonia-23 Vaccine		
Flu Vaccine		
Tetanus Vaccine		
Shingles Vaccine		
Colonoscopy		
PSA (prostate-specific antigen)		
Mammogram		
Pap Smear		
Bone Density		

Health Questions

Have you fallen in the last 3 months? ☐ Yes ☐ No

Do you have problems controlling your bladder? ☐ Yes ☐ No

Do you have depression or anxiety? ☐ Yes ☐ No

Do you have any pain? ☐ Yes ☐ No

Do you exercise regularly? If yes, how often? ☐ Yes ☐ No

How often? _____

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HIPAA EMAIL CONSENT

IMPORTANT — PLEASE READ

HIPAA was passed by the U.S. government in 1996 to establish privacy and security protections for health information. Information stored on our computers is encrypted.

Most popular email services (such as Hotmail®, Gmail®, and Yahoo®) do not use encrypted email. When we send you an email, or you send us an email, the information may not be encrypted. A third party may be able to access and read the information while it is transmitted over the Internet. Once received, someone may also be able to access your email account and read the message.

Option 1 — Allow Unencrypted Email

I understand the risks of unencrypted email and authorize East Jefferson Family Practice to send me personal health information by unencrypted email.

Signature: _____ Date: _____

Printed Name: _____

Email Address: _____

Option 2 — Do Not Allow Unencrypted Email

I do not wish to receive personal health information by email.

Signature: _____ Date: _____

Printed Name: _____

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TELEHEALTH CONSENT FORM

Patient Name: _____

I consent to receive healthcare services from my physician through Telehealth, which may use video, telephone, or other electronic communication. By signing this form, I understand and agree that:

1. My Telehealth visits and health information are private and protected by the same confidentiality laws that apply to in-person care, except where the law allows or requires disclosure.

2. Telehealth has risks, including technical problems, interruptions, miscommunication, privacy or security issues, and unauthorized access to electronic information.

3. I am responsible for being in a private location where I can speak freely and cannot easily be overheard.

4. At the beginning of each Telehealth visit, my physician will verify my full name and my current location.

5. Telehealth may not always be as effective as an in-person visit. If my physician believes I need to be seen in person, we will discuss my options.

6. I understand that Telehealth does not guarantee a particular medical result or outcome.

7. Neither my physician nor I may record a Telehealth session without the other person's written permission.

8. I have discussed Telehealth fees and/or insurance billing with my physician and understand my financial responsibility.

9. My physician will make reasonable efforts to provide information about emergency resources in my area. Telehealth may not be appropriate for emergencies. If I need emergency care, I will call 911 or go to the nearest emergency room.

10. I have had the opportunity to ask questions about Telehealth and have received answers that I understand.

11. Patient agrees to allow provider to charge a Telehealth visit when providing medical services, including, but not limited to:

-Rendering medical advice

-Setting up diagnostic or therapeutic services

-coordinating medical care

-changing/adjusting medications

-reviewing home results/compliance reports

By signing below, I confirm that I have read and understand this Telehealth Consent Form and agree to receive Telehealth services.

Patient Signature _____ Date Printed Name _____

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MEDICAL RECORDS CONSENT FORM

I authorize East Jefferson Family Practice to send and receive all of my medical records from all of my current and previous healthcare providers.

Print Name_____

Social Security #: _____

Signature: _____

Date of Birth: ____ / ____ / _____ Date: ____ / ____ / _____

FOR PROVIDERS & FACILITIES

Please fax records to: (504) 885-2510