DR. GREGORY DUPLECHAIN, M.D.
BOARD CERTIFIED OTOLARYNGOLOGIST

PATIENT INFORMATION

Last_____________________ First_______________________ MI_________ Preferred Name_____________

Mailing Address____ City/Zip _______________________

Driver's License #________________________ DOB______________________ SS#______________________

Sex: ___________ Race: ___________ Religion______________ Email_______________________________

Cell Phone #___________________ Home Phone #___________________ Work Phone #_________________

Receive Appointment Reminders? ☐Cell ☐Home ☐Work ☐No Thanks

Place of Employment____

Pharmacy of Choice (Please include Location) ____

SPOUSE INFORMATION

Spouse's Name________________________ Spouse's DOB________________

EMERGENCY CONTACT INFORMATION

Name___________________________ Phone #________________ Relationship to patient________________

If patient is a minor:

Mother's Name____________________ Phone #____________________ Place of Empl. _________________

Address____________________________________ SS#_____________________ DOB___________________

Father's Name_____________________ Phone #____________________ Place of Empl. ________________

Address____________________________________ SS#_____________________ DOB___________________

INSURANCE INFORMATION

Medicare #_________________________________ Medicaid #______________________________________

Insurance Company____________________________ Insured's Employer/Phone #______________________

Policy Holder's Name______________________________ Phone #_____________ DOB__________________

Relation to Insured________________________________ Identification #______________________________

If you have a second policy, please fill in below:

Insurance Company____________________________ Insured's Employer/Phone #______________________

Policy Holder's Name______________________________ Phone #_____________ DOB__________________

Relation to Insured________________________________ Identification #______________________________

I hereby assign, transfer, and set over to ACADIANA OTOLARYNGOLOGY (Dr. Gregory Duplechain) all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. This authorization is also valid for the release of medical records concerning my illness and treatment.

Signature____ Date___________________________

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