



Brian N. Heinen, MD
151 Leon Street
Eunice, LA 7053

Jade N. Heinen, MD
Ph: 337-457-8166
Fax: 888-371-3069

Welcome to Our Practice!

Patient Information

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Sex (circle one): Male Female Social Security Number: _____

Phone Number: Home: _____ Cell: _____ Work: _____

Race: _____ Language: _____ Preferred Pharmacy: _____

Email: _____

Marital Status (circle one): Married Single Other

Employer: _____

Guarantor Information

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Sex (circle one): Male Female Social Security Number: _____

Phone Number: Home: _____ Cell: _____ Work: _____

Race: _____ Language: _____

Emergency Contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Insurance Info:

Primary Insurance Company

Policy Holder: _____ Date of Birth: _____

Social Security: _____ Relationship to Patient: _____

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above insurance company and assign directly to Dr. Heinen all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Dr. Heinen to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Heinen or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient or Guardian Signature Date

I have received a copy of Brian N. Heinen, MD and/or Jade N. Heinen, MD Notice of Privacy Practices

Patient or Guardian Signature Date

NO SHOW POLICY

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In order to be respectful of the medical needs of other patients, please be courteous and call Heinen Medical promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we advise that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. This policy enables us to better utilize available appointments for our patients in need of medical care. A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show". After the 1st no show, our office staff will contact you by phone. After the 2nd no show, a letter will be mailed to you. After the 3rd no show, you may be dismissed from the clinic.

Patient or Guardian Signature Date



Brian N. Heinen, MD

151 Leon Street
Eunice, LA 70535

Jade N. Heinen, MD

Ph: 337-457-8166
Fax: 337-457-8564

I, _____, hereby authorize Dr. Brian N. Heinen or Dr. Jade N. Heinen to provide any medical information pertaining to my health to the following individuals:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name (print): _____

Name (signed): _____

Witness: _____

Date: _____