Bryan C. McCann, M.D.
424 N. Washington St.
Marksville, LA 71351
(318) 253-8136
(318) 253-5198

Name of Patient: **Sex:** **Social Security #:** **Date of Birth**

_____ **M / F** _____ _____

Mailing Address: _____
Home Phone: _____ **Work Phone:** _____
Cell Phone: _____
Email Address: _____
Name of Insurance Company: _____
Address of Insurance Company: _____
Name of Policy Holder: _____
Date of Birth of Policy Holder: _____
Social Security # of Policy Holder: _____
Policy #: _____ **Group #:** _____
Drug Allergies: _____
_____

I Authorize payment of medical benefits to Dr. Bryan C. McCann for services Rendered.
Signature: _____ **Date:** _____

Authorization for Medical Care: Permission is hereby granted for medical care, as may be advisable by the attending physician of this clinic. I understand that the Clinic will not be responsible for hospitalization charges, nor will it be responsible for other services unless specifically authorized. I agree that I have read and understand the above consent and will accept the terms.
Signature of Patient/ Parent/ Guardian: _____

DR. BRYAN MCCANN

PATIENT HISTORY

Patient Name:_____ DOB:_____

Any previous vehicle accidents or work accidents?: ☐ YES ☐ NO

If *YES*, what year(s)?: _____

If *YES*, any chronic pain since the previous accident/injury?: ☐ YES ☐ NO

Are you allergic to any medications?: ☐ YES ☐ NO

If *YES*, list all drug allergies: _____

CURRENT PATIENT MEDICAL PROBLEMS

Check all that apply

☐ High Blood Pressure	☐ High Cholesterol	☐ Hypothyroidism
☐ Diabeties Type 2	☐ Heart Disease	☐ Hyperthyroidism
☐ Diabeties Type 1	☐ Stroke	☐ Depression/Anxiety
☐ Asthma	☐ Acid Reflux	☐ ADHD

OTHER (Specify):_____

SURGICAL HISTORY

Check all that apply and provide what year the procedure took place. Please also provide the name of the suregon who did the surgery.

☐ Gallbladder Removal:	YEAR _____	SURGEON _____
☐ Appendix Removal:	YEAR _____	SURGEON _____
☐ Tonsil Removal:	YEAR _____	SURGEON _____
☐ Adenoid Removal:	YEAR _____	SURGEON _____
☐ Back Injections:	YEAR(S) _____	SURGEON _____
☐ Neck Injections:	YEAR(S) _____	SURGEON _____
☐ Heart Bypass:	YEAR _____	SURGEON _____
☐ Tubal Ligation:	YEAR _____	SURGEON _____
☐ C-Section:	YEAR(S) _____	SURGEON _____
☐ Hysterectomy:	YEAR _____	SURGEON _____
☐ Back Surgery:	YEAR(S) _____	SURGEON _____
☐ Neck Surgery:	YEAR(S) _____	SURGEON _____
☐ Heart Stent:	YEAR _____	SURGEON _____

OTHER (Specify): _____

PREGNANCY HISTORY

Check all that apply and fill in all blanks that apply

Number of **full term** pregnancies: _____

Any complications?: ☐ YES ☐ NO

If *YES*, please explain: _____

Number of **ectopic** pregnancies if any: _____

Number of **miscarriages** if any: _____

FAMILY HISTORY

Check all that apply and indicate which family member has the medical condition. We

- ☐ Stomach Ulcers: _____
- ☐ High Blood Pressure: _____
- ☐ High Cholesterol: _____
- ☐ Depression/Anxiety: _____
- ☐ Blood Disorders: _____
- ☐ Heart Disease: _____
- ☐ Asthma: _____
- ☐ Stroke: _____
- ☐ Diabeties: _____
- ☐ Cancer: _____

SOCIAL HISTORY

Check all that apply and fill in all blanks that apply

Smoker: ☐ YES ☐ NO

How many packs per day?: _____

How many years have you smoked?: _____

Occupation: _____

If DISABLED, what year did you become disabled?: _____

HEALTH MAINTENANCE

Check all that apply and provide what year the last, most recent test was done and name of business where it was done

☐ Colonoscopy:	YEAR _____	WHERE _____
☐ Prostate Exam:	YEAR: _____	WHERE: _____
☐ Pap Smear:	YEAR _____	WHERE _____
☐ Mammogram:	YEAR _____	WHERE _____
☐ X-Ray/MRI:	YEAR _____	WHERE _____
☐ Labs:	YEAR _____	WHERE _____
☐ Prostate Blood Work:	YEAR _____	WHERE _____

Patient: ______________________________ DOB: ______________

Medication Name	Dosage	Directions	Reason for Taking

DR. BRYAN MCCANN

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about you general medical condition and your diagnosis (including treatment, payment, and health operations).

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGANCY:

_____

_____

III. Please print the address of where you would like your correspondence from our office to be sent if other than your home.

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "Confidential":

_____YES NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and imaging results, and other health care information if other than your home phone number:

_____

I am fully aware that a cell phone is not a secure and private line.

VI. Can confidential messages be left on your telephone answering machine?

_____YES NO_____

VII. I am fully aware my health information can be transmitted by electronic transmission, by fax transmittal, by internet, or by e-mail.

_____ _____

Patient Signature/Legal Guardian Date

DR. BRYAN MCCANN

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Bryan McCann, M.D**. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Bryan McCann, M.D.**'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Bryan McCann, M.D.** reserves the right to revise his Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Bryan C. McCann, M.D.
Privacy Officer
424 N. Washington Street,
Marksville, LA 71351.

With my consent, **Bryan McCann, M.D.** may call my home, or other designated location, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others.

With my consent, **Bryan McCann, M.D.** may mail to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With my consent **Bryan McCann, M.D.** may e-mail to my designated e-mail address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Bryan McCann, M.D.** restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Bryan McCann, M.D.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Bryan McCann, M.D.** may decline to provide treatment to me.

I did receive a copy of the Patient Consent Form and Notice of the Privacy Practices.

_____ _____

Patient's Name Date

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME:		DOB:
ADDRESS:	SSN:	
CITY:	STATE:	ZIP:

PROVIDER RECEIVING PHI	ENTITY RELEASING PHI	
Bryan C. McCann, M.D. 424 N. Washington St. Marksville, LA 71351 Telephone: 318-253-8136 Fax: 318-253-5198	NAME:	
	ADDRESS:	
	CITY:	
	STATE:	ZIP:
	PHONE:	FAX:

This authorization will expire on the following date or event:	
DATE:	EVENT:

Purpose of this disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

	DESCRIPTION	START DATE	END DATE
☐	ALL PHI IN RECORD		
☐	PROGRESS NOTES		
☐	LABORATORY RESULTS		
☐	RADIOLOGY REPORTS		
☐	HISTORY AND PHYSICAL EXAM		
☐	DISCHARGE SUMMARY		
☐	CONSULTATION REPORTS		
☐	ITEMIZED BILLING STATEMENT		
☐	OTHER		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Psychiatric or mental care/treatment
[ ] Alcohol, drug, or substance abuse treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1.) I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY
2.) MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION
3.) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WIRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION
4.) IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MY BE DISCLOSED
5.) I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT

SIGNATURE OF PATIENT: SIGN ONLY	DATE:
SIGNATURE OF PATIENT'S REPRESENTATIVE (IF NECESSARY):	DATE:
PERSONAL REPRESENTATIVE'S RELATIONSHIP TO PATIENT:	