



# PATIENT INFORMATION (please print clearly)

Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient Name: (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_

Maiden/Other Name: (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_

Address: \_\_\_\_\_ Apt./Lot: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Sex:  Female  Male Race: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Pager: ( ) \_\_\_\_\_

## EMERGENCY CONTACT

Name: (Last): \_\_\_\_\_ (First): \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

## NEXT OF KIN

Next of Kin Name: (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Home/Work Phone: ( ) \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Patient's Religion: \_\_\_\_\_ Living Will:  Yes  No Power of Attorney:  Yes  No Organ Donor:  Yes  No

Patient Speaks English:  Yes  No Do you have Medical Insurance:  Yes  No

## RESPONSIBLE PARTY INFORMATION

Responsible Party Name: (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed Sex:  Female  Male

Home Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

### PRIMARY INSURANCE TO FILE

Policy: \_\_\_\_\_ Group #/Group Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber's Address: \_\_\_\_\_  
Subscriber's Social Security Number: \_\_\_\_\_ or ID Number: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insurance Phone: (     ) \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

### SECONDARY INSURANCE TO FILE

Policy: \_\_\_\_\_ Group #/Group Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Subscriber's Address: \_\_\_\_\_  
Subscriber's Social Security Number: \_\_\_\_\_ or ID Number: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insurance Phone: (     ) \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

### PATIENT EMPLOYER INFORMATION

Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Employer Phone: (     ) \_\_\_\_\_ Employment Status:  Full Time  Part Time

### ADDITIONAL INFORMATION (Only for those patients 18 years old and younger)

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians as requested by any such insurer or physician. **I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, private insurance, group policy benefits and other health plans to LMC Physician practices. LMC physician practices do not extend credit. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection.** I understand that I am financially responsible to LMC physician practices for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set up with the business office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_