

PATIENT INFORMATION - Please Print Clearly

Date: _____ SS#: _____

Patient Name: (Last) _____ (First) _____ (MI) _____

Address _____ **Apt./Lot** _____ **City** _____ **County** _____ **State** _____ **Zip** _____

Date of Birth: _____ Age: _____ Marital Status: () S () M () D () W Sex: () Female () Male

Home Phone# (w/ area code) _____ Work Phone# (w/ area code) _____

Cell Phone# (w/ area code) _____ Pager# (w/ area code) _____

Responsible Party Name: (Last) _____ (First) _____ (MI) _____

Address _____ City _____ State _____ Zip _____

Date of Birth: _____ Age: _____ Marital Status: () S () M () D () W Sex: () Female () Male

Home Phone# (w/ area code) _____ Work Phone# (w/ area code) _____

Employer/School _____ Occupation _____

Employer Address _____

Do you have medical insurance? () Y () N Primary Care Physician _____

PRIMARY INSURANCE TO FILE

Policy# _____ Group# _____ Insured Date of Birth _____

Insured's Name _____ Relationship to Patient _____

Insured's Address _____ Insured's SSN or ID # _____

Insurance Co. Name _____ Insurance Phone # _____

Insurance Address _____

SECONDARY INSURANCE TO FILE

Policy# _____ Group# _____ Insured Date of Birth _____

Insured's Name _____ Relationship to Patient _____

Insured's Address _____ Insured's SSN or ID # _____

Insurance Co. Name _____ Insurance Phone # _____

Insurance Address _____

Emergency Contact _____ Phone # _____

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.

Signed _____ Date _____

Signed _____ Date _____

Responsible Party Signature (if different)