Last Name: _________________________ **First Name:** ________________________ **Middle Initial:** _____

Gender : M F **Social Security #:** ___________________ If refused, *please initial* ______

Marital Status: Single Married Divorced Widowed Separated

Date of Birth: ______/______/______

Race: White Native American Black Asian American Indian/Alaska Native Other

Ethnic Group: Hispanic Non-Hispanic Unknown **Declined** ***please initial:*** ______

Primary Language: ____

Primary Provider: □ ACKLEY □ COREIL □ DENNIS □ DOWDEN

□ HEBERT MIER □ PETRY □ RIGGS

Street Address/City/State/Zip: ____

Mailing address (if different than above): ____

Telephone: **Home #:**_________________ **Cell #:**_________________ **Work #:**______________**Ext**____

E-mail address: ______________________________________

Preferred Contact Method: Phone Text Mail Email Secure Email

Preferred Reminder Method: Cell # Home # Work # Mail

Preferred Pharmacy (Include Street/Location): ____

Preferred Mail Order Pharmacy (if applicable):____

Patient's Employer: __________________________________ **Employer's Phone #:** ___________________

Employer's Address/City/State/Zip: ____

Occupation: ___________________ Full-Time Part-Time Self-Employed Retired Student

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GUARANTOR INFORMATION (Policy Holder's Info)

Guarantor Name: ________________________ **Guarantor DOB**: _______ **Guarantor Sex:** **M** **F**

Guarantor Address/City/State/Zip ____

Relationship to Guarantor: Self Spouse Child Other: ________

INSURANCE INFORMATION

Primary Insurance: ________________________ **Tertiary Insurance: ________________________**

Secondary Insurance: ______________________

****A copy of your insurance card and other ID is required for billing*****

EMERGENCY CONTACT

Name: ____________________________________ **Relationship to patient: _________________________**

Mailing Address/City/State/Zip: _________________________________

Home # ______________________ **Work #** _______________________ **Cell #** _______________________

Referring Doctor: _______________________________ **Referring Doctor Phone #**:____________________

How did you hear about Lafayette Internal Medicine Clinic: ______________________________________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Lafayette Internal Medicine Clinic or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or insurance companies or third parties, any information needed to determination these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or insurance payments of medical benefits be made to Lafayette Internal Medicine Clinic or to any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

GUARANTOR RESPONSIBILTY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Lafayette Internal Medicine Clinic, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court. This authorization and assignment may be revoked by me at any time by a written notice. I agree that a photocopy of this form may be used in used in lieu of the original.

Signature of insured/patient __________________________________ Date: ______________