

PATIENT INFORMATION SHEET

Patient Information:

First Name _____ Soc. Sec. # _____
 Middle Initial _____ Birth Date ____/____/____
 Last Name _____ Employer _____
 Address _____ Your Doctor _____
 Apt # _____ Race _____
 City _____ Ethnicity: Hispanic or Latino/ Not Hispanic or Latino
 State _____ Zip _____ Primary Language _____
 Home Phone _____ Work Phone _____
 Cell Phone _____ Gender (circle one): Male Female
 Marital Status (circle one): Married Single Widowed Divorced Separated Other

NAMES OF HOUSEHOLD MEMBERS	RELATIONSHIP TO PATIENT	BIRTH DATE	PRIMARY INSURANCE COVERAGE
		____/____/____	
		____/____/____	
		____/____/____	
		____/____/____	
		____/____/____	

Responsible Party (Person to whom we should send the bills): Check if same as patient

First Name _____ Street Address _____
 Middle Initial _____ City _____
 Last Name _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 Cell Phone _____

Relationship to Patient: _____

Co-pay and Proof of Insurance are required at time of service

Please complete backside

Emergency Contact: (Relative or Close Friend to contact in case of emergency)

Name _____

Home Phone _____

Work Phone _____

Cell Phone _____

Relationship to patient: _____

As a condition of providing treatment to you, Lawrence Family Practice Center (LFPC) obtains your consent to use and disclose Protected Health Information (PHI) about you to carry out treatment, payment, and the health care operations (TPO) of LFPC.

You may revoke this consent at any time by notifying LFPC in writing, except to the extent LFPC has taken action and reliance on your consent.

Effective April 14, 2003, please refer to the Notice of Privacy Practices for PHI "Privacy Notice" for a more complete description of the used and disclosures that LFPC may use of your PHI. By signing you acknowledge receipt of Privacy Notice.

You have the right to request LFPC to restrict the manner in which your PHI is used or disclosed to carry out treatment, payment, or health care operations according to Privacy Notice.

With my consent, LFPC 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 reminder cards, insurance items, and any call pertaining to my clinical care, including laboratory results.

With my consent, LFPC or its billing representative 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.

I understand that I am responsible for proof of insurance and co-pay at time of service. Without proof of insurance I am responsible for full payment at time of service.

Signature of Patient or Legal Guardian

Printed Name

Patient's Name

____/____/____
Date