PATIENT INFORMATION Today's Date: _______________

Date of Birth:_____/_____/______ Patient SSN: _________-________-________ Married Single Divorced Widowed (Circle One)

Patient's Legal Name: ____ Full Time Student? Y/N (Circle One)

Street Address: ______________________________________ City: ______________ State: ______ Zip: ___________

Emergency Contact Name: ______________________________ Phone Number: ____________________________

**At times our office will need to call you to discuss lab/x-ray results, medications, scheduling, etc.. It is Important that you list any and all phone #'s you may be reached at along with the best time to call. If patient is a minor, provide name of parent/legal guardian to ask for.

Home: (_______) ________-___________ Best time to call: ___________________

Cell: (_______) ________-___________ Best time to call: ___________________ Carrier: ___________________

Work: (_______) ________-___________ Best time to call: ___________________ Extension: ________________

**E-Mail ____

Race: _________________________ Ethnicity: ________________________ Gender: __________________

Patient's Employer___________________________________ **If patient is a minor, parent/legal guardian's employer

Insurance Company Name: ___________________________

Name of Policy Holder: ___________________________ Policy Holder's DOB: ______________________

SSN of Policy Holder: ____________________________ Relationship to Patient: Self Spouse Parent

Policy Holder's Address: ____

Phone Number: ______________________ **If a minor, who is financially responsible for charges? _____________

I hereby grant permission for the attending physician and medical staff to give necessary medical treatment to myself/patient. I hereby authorize my insurance benefits be paid directly to Life Care Family Practice, P.C., realizing I am financially responsible to pay for any non-covered services. I also authorize the release of pertinent and protected health information to my insurance carrier for the purpose of medical planning and treatment, payment, or other healthcare operations.

Patient's Signature: ______________________________ Parent/Legal Guardian Signature: ___________________________